MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 19th FEBRUARY 2024 - DAY 77

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THE HEARING COMMENCED ON MONDAY,
19TH DAY OF FEBRUARY, 2024 AS FOLLOWS:

OPENING REMARKS BY THE CHAIRPERSON:

10:06

CHAIRPERSON: Right, thank you. So apologies for the late delay this morning, we've got Internet problems, we're going to struggle on. I gather things are working sufficiently to have the witness but we may have to stop part way through, so we will just have to see how we go. 10:12

But before we call the witness I have got a short statement to make in relation to a delay that I am afraid is going to have to occur to this Inquiry. 10:13 After this week, the schedule of the Inquiry is going to be altered and there will be a delay in further sittings and I am going to explain why that's going to happen.

10:13

As you all know, the Panel had intended to finish the evidence by the end of June this year. That would have been a significant challenge but not an impossible one. The reason there is going to be a delay relates to my health and I want to be as open as possible. I have 10:13 been diagnosed with a heart condition that requires surgery and that should not be delayed. It will take place in the week of 26th February, in other words next week. I've been told that physical recovery from the

1 operation may take at least six weeks. However,
2 I expect to be able to make any necessary decisions and
3 make any orders that require my authority during my
4 recovery period.
5 10:13
6 I want to apologise to all Core Participants and
7 especially to the relatives and patients concerned and
8 also to all those who may have been preparing to give
9 evidence and will no doubt be anxious. If I could have
10 avoided this delay, I would have done. However, I want 10:14
11 to state clearly that the current timescales for the
12 receipt of evidence must be adhered to, unless there
13 are exceptionally good reasons not to do so. The work
14 of the Inquiry teams, counsel, Inquiry solicitor and
15 the administrative team, as well as the solicitors 10:14
16 working on our behalf taking statements will continue
17 to proceed at the same pace. The deadlines for the
18 organisational statements must also still be adhered
19 to. This is not a reason to slow down the pace of
20 preparation in any way. 10:14
21
22 We'll hear the evidence this week, with our last
23 witness being on Wednesday, but we will then pause and
24 we propose to re-start hearings on the 7th of May, all
25 being well. 10:15
26
27 When we re-start we're likely to revert to continuing
28 with the staff evidence, but before the end of June
29 I intend that we will have completed evidence Module 6

1 and modules M1 to M6 of the organisational evidence.
2 We'll then be sitting in September and October to hear
3 the remainder of the evidence relating to
4 organisational modules M7 to M10.
5 10:15
6 I have written to the Minister of Health to explain why
7 this delay is having to take place. I will not make
8 any further comment on what I know you will all
9 understand is a very personal matter. Okay, are we
10 ready for the witness? Let's get the witness in. 10:15
11 MS. TANG: Can I check everyone can hear me okay.
12 CHAIRPERSON: Yes, and I think we have got the
13 stenographer, if there are any problems just let us
14 know.
15 MS. TANG: Panel, this morning the Inquiry will hear 10:16
16 from Ms. Jan McGall as part of evidence for the staff
17 evidence relevant to MAH. She has appeared previously
18 on behalf of the Southern Health and Social Care Trust
19 in relation to Module 2. She has given a total of
20 three statements to the Inquiry and this is the third 10:16
21 of those, the reference for that is STM-200.
22
23 MS. JAN McGALL, HAVING BEEN SWORN, WAS DIRECTLY
24 EXAMINED BY MS. TANG AS FOLLOWS:
25 10:16
26 CHAIRPERSON: Ms. McGall, can I just welcome you back
27 to the Inquiry, I think you've sat there before.
28 Hopefully this will be the last time and I'll hand you
29 over to Ms. Tang.

1 A. Okay, thank you.
2 MS. TANG: Hello again. I'm Shirley Tang, we met
3 briefly earlier on, I am one of the barristers working
4 for the Inquiry and you're very welcome. What I am
5 going to do is read your statement through, first of 10:17
6 all, and if you could just listen to that and,
7 following that reading through, I'll ask you if you are
8 content to adopt that as your evidence. I may skip
9 through a certain amount so that we can focus on the
10 areas that we're going to be speaking about after. 10:17
11 A. Okay.
12 1 Q. "I Jan McGall make the following statement for the
13 purpose of the Muckamore Abbey Hospital Inquiry. There
14 are no documents produced with my statement. My
15 connection with MAH is that I was a Senior Service 10:17
16 Improvement Manager, Band 8C, at MAH on secondment for
17 a six month period from September 2019 to February
18 2020. The relevant time period I can speak about is
19 from September 2019 to February 2020."
20 10:17
21 You then go on to state that you are currently Director
22 for Mental Health and Disability Services in the
23 Southern Health and Social Care Trust and you provide a
24 little information about your education and your
25 background and your career up to the point where you 10:18
26 joined Belfast Trust on graduation.
27
28 I'm going to pick up at the very bottom of paragraph
29 three, if I may, which is the last sentence:

1
2 "In 2017, I took up a Band 8B Service Manager post in
3 the division of Community and Partnerships in the
4 Belfast Trust. I was based in the Mater Hospital
5 Belfast. 10:18
6
7 Whilst in the employment of the Belfast Trust,
8 I completed corporate mandatory training on areas
9 including adult safeguarding, manual handling,
10 management of complaints, fire safety, staff management 10:18
11 and recruitment and retention. Some of this training
12 was on a one-off basis, yearly, twice yearly or three
13 yearly updates. In addition, supported by the Belfast
14 Trust, I completed management and leadership training
15 provided in the main by the Health and Social Care 10:19
16 Leadership Centre. As a registered Occupational
17 Therapist, I am also required to undertake continuous
18 professional development specific to my profession and
19 areas of specialism.
20 10:19
21 I had experience of improving services provided by the
22 Belfast Trust when I was an Assistant Service Manager
23 from 2015 to 2017 and a Service Manager from 2017 to
24 2019. For example, the Community Addiction and
25 Substitute Prescribing Team experienced a significant 10:19
26 increase in referrals resulting in high waiting lists
27 and the model of care was insufficient to provide safe
28 and effective care. Through service review and staff
29 development and service reform, I delivered reduced

1 waiting times, new ways of working and improved service
2 safety and quality.
3 In and around the summer of 2019 I was advised of a
4 secondment opportunity at MAH. I cannot recall who
5 advised me of the opportunity. I was aware that H287 10:20
6 Co-Director had retired and that there had been several
7 recruitment campaigns for the Co-Director post that had
8 not been successful. I was aware of the pressures in
9 MAH related to an adult safeguarding PSNI investigation
10 and there was a gap at managerial level which needed to 10:20
11 be urgently filled as RQIA had issued three improvement
12 notices to the Belfast Trust on MAH relating to one,
13 safe staffing; two, patient finances; and, three,
14 safeguarding practices.
15 10:20
16 I completed an expression of interest form and I was
17 interviewed for the post by H296, the Director of MAH
18 and Mel Carney, Interim Director for Mental Health
19 Services at Belfast Trust.
20 10:20
21 I was successful in securing the secondment and
22 commenced in early September 2019 as Service
23 Improvement Manager. I had no family or friends
24 working in MAH. As well as addressing the RQIA
25 improvement notices, I was also required to provide 10:21
26 day-to-day management and leadership presence on the
27 MAH site and contribute to the stabilisation of the
28 service to include staffing levels, care delivery and
29 resettlement. H831 was also interviewed for the same

1 secondment post as myself and took up a post of Band 8C
2 Resettlement Lead in MAH a few weeks after I started."
3 And you go on to provide a little bit of detail on that
4 individual.
5 10:21
6 Sorry, yes, picking up again:
7
8 "I was advised that the post would be for four months
9 but I was there for six months, to February 2020.
10 During this time, there was an improvement team 10:21
11 identified for MAH. H301 was coming as Co-Director.
12 I believe she came from being the Co-Director in Cancer
13 Services, Band 8D."
14
15 And you go on to describe a number of other individuals 10:22
16 that came in to work alongside you.
17
18 I'm going to move past those and pick up then towards
19 the end of that paragraph, the last sentence:
20 10:22
21 "We were all recruited to try to stabilise the
22 management and leadership of MAH on a Safe Today, Safe
23 Tomorrow approach and to try to progress resettlement.
24
25 I had never been in MAH prior to starting my position 10:22
26 in September 2019. The first thing that was apparent
27 was the absence of a management structure which I was
28 used to working in other parts of the Belfast Trust.
29 I was used to a structure of having a Director and a

1 Co-Director with a variety of Band 8B Service Managers,
2 8A Assistant Service Managers and Band 7 Team Leads and
3 Ward Managers leading teams and directly supervising
4 frontline staff.
5 10:23
6 I could not comment on the culture of the management as
7 there was no management structure when I came to MAH.
8 When I started there was only H296, a Director, and
9 H394, who was the Corporate Nursing Co-Director, Band
10 8D. I understood that there had been a number of 10:23
11 retirements and long-term sickness absences in the
12 management structure. There were a few Band 7 Ward
13 Managers in post, some of whom were early in their
14 career with no other management line until Co-Director
15 or Director level. This was unusual in my experience 10:23
16 of line management structures. It was apparent that
17 there was a need for a stable management and leadership
18 structure.
19
20 On arrival in MAH my impression was of a fragile staff 10:23
21 group doing their best in unprecedentedly difficult
22 circumstances. Agency staffing levels were high, with
23 registered mental health nurses from England having
24 been brought into the workforce by Belfast Trust to
25 replace staff who had been placed on precautionary 10:24
26 suspension and due to the lack of available registered
27 learning disability nurses.
28
29 I recall there were around 40 patients who required

1 care at MAH. My impression of the service was that
2 there was an understanding of the need for and attempts
3 to action resettlement of patients, balanced by the
4 daily focus on trying to adequately staff the wards to
5 provide daily care. There was also a need for greater 10:24
6 engagement by placing Trusts to drive forward
7 resettlement. There was a significant internal and
8 external focus on the running of the hospital.
9
10 I recall that there were system issues that I needed 10:24
11 greater clarity on when I started, particularly around
12 staffing. There was a Telford exercise in relation to
13 safe staffing levels being carried out by the Corporate
14 Nursing Team in the Belfast Trust. This allowed each
15 ward to understand a minimum safe staffing level and 10:24
16 skill set required to care for the assessed patient
17 need. My concern was that there was a high ratio of
18 unregistered staff and there was a need to ensure that
19 there was enough registered learning disability nurses
20 on each shift to support the registered agency mental 10:25
21 health nurses and the unregistered staff.
22
23 For the first three to four weeks of my time in MAH
24 I worked with the Ward Managers and Service Improvement
25 Manager alongside Francis Rice to focus on ensuring 10:25
26 safe and effective staffing levels. This
27 responsibility passed to H315, the Divisional Nurse,
28 when she started in MAH. Staffing pressures were
29 common throughout my time in MAH due to an unavailable

permanent workforce, limited learning disability nurses in Northern Ireland who wished to join the workforce, ongoing precautionary suspensions and sickness absence, as well as the beginning of industrial action.

On my arrival in MAH there was one permanent 8A in post who was off on a period of extended leave. She returned around three weeks after I moved to MAH. H290, a former 8A Operations Manager in MAH, returned from retirement on a part-time basis and H308, a retired Band 8B Service Manager, who I had worked with in Mental Health Services in Belfast Trust, also returned to support MAH. The input of these three experienced nurses offered support to the Band 7 Ward Managers and supported the stabilisation of the management team.

Initially I also had responsibility for making sure patient care plans were reviewed to reflect current need and intervention. This was a standing agenda item on the weekly Ward Manager meeting. I also tried to facilitate meetings with placing Trusts to focus on the resettlement agenda.

RQIA had issued an improvement notice in respect of the processes around the management of patient finances in MAH. Improvements were required in the financial management systems, how finances were managed at ward level, how patient property accounts were monitored and

1 how finance was used to meet the wishes of patients and
2 their needs.
3
4 In response, support was provided by the finance team
5 in the Belfast Trust in the review of the policy and 10:27
6 procedures around the management of patient finances as
7 well as providing finance training to ward staff.
8 There was also training provided by the Directorate of
9 Legal Services with regard to understanding capacity.
10 A finance officer was appointed, I cannot recall her 10:27
11 name. Her role was similar to the role performed in
12 community learning disability teams to support the
13 management of patient finances, establishing budget
14 plans with the patients, advocates and family and
15 engaging with benefit offices. Day-to-day management 10:27
16 of patient finances was a procedurally laborious
17 process with registered nurses required to review money
18 held at ward level at the commencement and cessation of
19 each shift. In my time in post in MAH there was a
20 significant improvement in the processes around 10:28
21 financial management and I understand after I left MAH
22 a subsequent RQIA inspection noted this and the
23 improvement notice was concluded.
24
25 H831's role was to support patient resettlement. I had 10:28
26 a limited role beyond supporting the ward staff to
27 engage in assessments to plan resettlement and
28 facilitate a few meetings with placing trusts to try
29 and support resettlement planning. I observed that it

1 was not an easy job to work in learning disability on
2 the wards in MAH. It requires a very specialised skill
3 set to safely manage and look after the patients.
4 Staff needed to be resilient. Patients have limited
5 levels of independence. I observed evidence of 10:28
6 patient-centered care, the staff knew each patient and
7 what they liked and did not like. I recall a male
8 patient in Cranfield 1 where the staff knew that this
9 patient liked photographs of his family and they
10 arranged to get family pictures printed onto cushions 10:29
11 for his bedroom. Another patient like McDonald's food
12 and it was written into his care plan to make sure that
13 there were visits to McDonald's. Staff took care of
14 the patients holistically in the different ward
15 environments. Staff tried to work to support 10:29
16 successful resettlement of patients.
17
18 I recall a patient was to be resettled out of Cranfield
19 1 and the staff knew he loved music. The staff
20 advocated that some of his money was used to purchase a 10:29
21 music system for his new home where he was being
22 resettled. I cannot recall specific names of any of
23 the patients or of the staff. There were staff in MAH
24 dedicated to providing the best care they possibly
25 could. It was a challenging environment as there was 10:29
26 ongoing review of historical CCTV as part of the PSNI
27 adult safeguarding investigation and this resulted at
28 times in staff being placed on precautionary suspension
29 or on to protection plans. Staff were anxious about

1 what was going to happen in the future. I supported
2 the staff as best I could and I received feedback that
3 this was acknowledged and appreciated by staff. For
4 example, in the event of a member of staff being
5 assaulted by a patient, when I was notified I made sure 10:30
6 that the Ward Manager had made contact with the staff
7 to check how they were and if a referral to
8 Occupational Health or Staff Care was required. When
9 I was on the ward I would personally ask the staff
10 member how they were doing following the assault and if 10:30
11 there was anything further we could do to provide
12 support.
13
14 There were significant levels of aggression towards
15 staff by patients at varying degrees of harm. I made 10:30
16 sure that the staff who were returning following an
17 assault felt ready to go back to work and that any
18 adjustments that were needed were implemented, such as
19 moving to another ward or not working closely with the
20 patient who had carried out the assault. This was to 10:31
21 make sure that staff could carry out their job safely.
22
23 I visited the wards in MAH most days when I was in this
24 role. The patient population was different across the
25 wards. There was Cranfield 1 and Cranfield 2 10:31
26 assessment and treatment. I would describe these as
27 more acute wards as they accepted newly admitted
28 patients. There were significant behavioural issues
29 and incidents of self injurious and assaultive

behaviours on these wards.

Six Mile Ward was a ward for patients with a forensic history and had a different culture as there were legal restrictions on patients' freedoms. The patients on Six Mile Ward had varying degrees of ability. There was also an absence of experienced senior staff members on Cranfield and Six Mile Wards due to staff leaving and suspensions.

Erne Ward had some patients in their own areas. These areas were known as pods and patients in the main spent the majority of their time living aside from peers, sometimes with presence of one-to-one staffing in these areas. My understanding was that the decision for pods was based on a care plan decision that involved individual living best suited to the patient's assessed needs. The patients on Erne Ward were amongst the first identified for resettlement during my time in MAH. It was a female ward with two sides, one for treatment and one for assessment. Moyola was the day care area. Staff were moved between the different wards at MAH to cover staff shortages and therefore all of the staff seemed to know the majority of the patients in the hospital, whatever ward they were on.

I did not personally witness any poor care or abuse during my time in MAH. There were, however, allegations regarding staff on patient safeguarding

1 issues. The majority of reported allegations of this
2 nature came to me in real time, as in they were
3 reported to me as soon as practicable as they occurred
4 and reported at the weekly live governance meeting,
5 which I attended. AJP 1 forms were completed by staff 10:33
6 reporting an adult safeguarding concern and during my
7 time in MAH, RQIA also introduced the requirement for a
8 Form 2 notification to be completed for any staff on
9 patient or serious patient-on-patient allegation or
10 incident. 10:33
11
12 In normal operational practice, RQIA are only informed
13 of very significant events through a Form 2. However,
14 given the scrutiny MAH was under at that time and, as a
15 result of the improvement notices, we had to report 10:33
16 every staff-on-patient allegation or significant
17 patient-on-patient allegation. There was also
18 contemporaneous CCTV viewing taking place in relation
19 to what was happening on the ward. This also at times
20 highlighted potential safeguarding practice issues 10:33
21 which required investigation. During my time at MAH
22 I was responsible for organising the contemporaneous
23 CCTV reviewing.
24
25 Prior to me starting my post, H351 was in charge of the 10:34
26 CCTV review and had established the policies and
27 protocols around this. External reviewers came in and
28 reviewed the CCTV footage, the majority of whom were
29 retired nurses or social workers from either learning

1 disability or Mental Health Services who had a working
2 knowledge of good patient care, management of potential
3 and actual aggression and adult safeguarding. CCTV was
4 reviewed from what was recorded on the previous week
5 and there was a random selection of days, shifts and 10:34
6 times to be viewed. If there were any concerns as to
7 what was reviewed, the adult safeguarding process was
8 commenced.
9
10 During my time in MAH there was a focus on 10:34
11 understanding the use of restrictive practices,
12 including low level, medium level and high level holds,
13 PRN medication administration, seclusion and voluntary
14 confinement. These practices were reported via Datix
15 and on a weekly basis reviewed at the live governance 10:35
16 meeting which was chaired by the Clinical Director and
17 attended by all Ward Managers and at times aligned ward
18 consultant psychiatrists. Trend analysis could be
19 completed on restrictive practices after a period of
20 time. 10:35
21
22 I also had a role in liaising with PSNI and providing
23 staff personnel information such as training records as
24 part of the ongoing criminal investigation. I liaised
25 with both the information governance lead in Belfast 10:35
26 Trust and the Directorate of Legal Services to ensure
27 that staff details were provided in accordance with
28 GDPR. The PSNI usually issued a Form 81 for release of
29 staff personnel details to the Belfast Trust. I would

1 then have gathered the information requested by the
2 PSNI, ensure that I was complying with GDPR and sent
3 the information on to the PSNI. H308 took over this
4 role when I left MAH.
5 10:36
6 I recall there was a live governance meeting for all
7 wards every week which took place by teleconference.
8 These meetings were chaired by the Clinical Director
9 and this meeting was attended by each Ward Manager and
10 usually the aligned consultant for each ward. Minutes 10:36
11 were taken of the minutes and a weekly report produced.
12 I attended these meetings as the senior management
13 staff grew, the Band 8A, who returned from absence,
14 H290 and H308 also attended if they were at work.
15 10:36
16 There was a standard reporting template which
17 considered the following: Numbers and types of
18 physical interventions, self-injurious behaviour,
19 patient on staff, patient on patient issues and staff
20 on patient issues. We discussed trends on certain 10:36
21 incidents and, for example, whether there were regular
22 occurrences at a particular time of day or night.
23
24 On a Friday morning the Ward Managers had a meeting to
25 discuss operational issues, which included, amongst 10:37
26 other things, staffing levels, day-to-day running of
27 the wards and an update on completion of care plans for
28 patients. There was also a monthly meeting of the
29 community and MAH staff which focused on the service

1 improvement recommendations from visiting Trusts to
2 MAH, development of community alternatives to admission
3 to hospital and implementation of the Mental Capacity
4 Act. Resettlement progress was discussed at a high
5 level. I did not attend very many of these meetings 10:37
6 but I know that minutes were taken of the meetings.
7
8 There was a policy for staff to follow in the use of
9 restrictive interventions. Restrictive interventions
10 such as segregation and seclusion were noted in the 10:37
11 patient care plans following discussion by the
12 multidisciplinary team. I recall this process and
13 policy was being reviewed when I was at MAH. There was
14 a growing level of understanding on the practice of
15 recording the use of restrictive practices, especially 10:38
16 when the restrictive intervention was requested by the
17 patient, for example in the circumstances of a patient
18 requesting voluntary confinement. Staff knew that
19 restrictive practices had to be recorded when used as
20 an intervention. 10:38
21
22 I recall one specific patient who requested voluntary
23 confinement, he requested that his bedroom door be
24 locked. I was aware that there was well acknowledged
25 history of restrictive practice usage at MAH. I recall 10:38
26 that there was some seclusion used when I was in MAH
27 but it was not a significant occurrence. I would
28 estimate that there were less than 10 instances during
29 my six months. If I was present on site I was notified

1 by the nurse in charge of the time when seclusion
2 commenced, how long it was used for, the time it ended,
3 the location and the reason for the seclusion.
4 I recall viewing two patients who were placed into
5 seclusion when I was on shift at MAH. There was no 10:39
6 requirement for me to attend but I did attend on the
7 two occasions which had been notified to me whilst
8 I was physically on the MAH site. Medical staff were
9 consulted and advised on the starting cessation of
10 seclusion. I did not think the seclusions notified to 10:39
11 me were outside of what was necessary for the
12 particular circumstances happening at the time. Senior
13 management reviewed trends and analysis of the use of
14 seclusion. We also reviewed the use of PRN medication
15 weekly. We reviewed the use of holds and trends of 10:39
16 restrictive practices over time. Restrictive
17 interventions are sometimes required whilst caring for
18 patients with learning disabilities but the question is
19 how to minimise their usage and examining the safe
20 alternatives. 10:39
21
22 I felt supported in my role. I had the support of H296
23 and H394. I was there to assist them until H301 and
24 H315 came to MAH. I raised any concerns I had with
25 either H296 or H394 as appropriate. When H301 became 10:40
26 Co-Director in MAH, we had weekly supervision meetings
27 and if I had any issues I discussed these with H301 or
28 H315.
29

1 I was also welcomed to MAH by the ward staff. They
2 appreciated having someone to provide support and
3 guidance. I had no difficulty with people engaging
4 with me. They knew I was there to help. There were
5 regular visits from Cathy Jack, Chief Executive of the 10:40
6 Belfast Trust, and Brenda Creaney, Executive Director
7 of Nursing. My role in MAH was primarily to address
8 the three improvement notices issued by RQIA and to
9 assist with the operational management of the hospital.
10 I left MAH in February 2020 as I had been successful in 10:40
11 applying for a post of Assistant Director for Mental
12 Health Services at the Southern Trust.
13
14 In the summer of 2020 I was advised that RQIA had
15 conducted a further inspection of MAH and removed all 10:41
16 three improvement notices. I believe I helped to
17 bridge the gap between the absence of management to the
18 arrival of a substantial management team. I feel
19 I performed that role I was seconded to during my time
20 in MAH." 10:41
21
22 And you go on to confirm your wishes around giving
23 evidence and provide a declaration of truth in the last
24 page. The statement is signed and dated 8th February
25 2024. Can I check that you are content to adopt that 10:41
26 statement as your evidence to the Inquiry?
27 A. Yes, just one minor amendment. In paragraph six, Mel
28 Carney, he was the Interim Co-Director for Mental
29 Health Services, not the Interim Director.

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1 2 Q. Did I read out "Director"?
2 A. No, I hadn't put "Co-Director" in my statement, so once
3 that is made, yes, I am happy to accept it.
4 3 Q. Thank you, that's noted. I have a few questions for
5 you just on the content of your statement. I want to 10:41
6 take you, first of all, to paragraph 5. I wanted to
7 ask you, you mentioned that your secondment was for six
8 months, was that how long it was intended to be or did
9 you think that there was an expectation that you would
10 have stayed longer? 10:42
11 A. The paperwork for the secondment noted four months --
12 4 Q. Yes.
13 A. -- as the time duration. I was there for six months
14 because I then took up a post outside of the Trust.
15 I think if I hadn't have taken up a post outside of the 10:42
16 Trust it would have been likely that I would have been
17 staying on in Muckamore for a period of time.
18 5 Q. So when you said four months, was it four months
19 initially subject to review?
20 A. Yes. 10:42
21 6 Q. Okay. Whenever you came to MAH did you already have or
22 were you given any training in learning disability
23 particularly?
24 A. So, I have, obviously, my professional qualification in
25 occupational therapy and I had completed a student 10:43
26 placement in a children's disability team, which
27 included children with learning disabilities. So
28 whilst I had no direct adult clinical experience, I had
29 clinical experience of the understanding of learning

1 disabilities and the application to children.
2 7 Q. So you brought that with you to the post. Was there
3 any sort of induction given for adult learning
4 disability services once you came to MAH?
5 A. Once I went to Muckamore I suppose it was my 10:43
6 responsibility then to try and find out what was going
7 on in the wards. So I recall meeting with the
8 behaviour support team and then trying to engage with
9 the Ward Managers and nursing staff to understand their
10 roles and meeting with the Clinical Director to 10:43
11 understand the role of medicine. So whilst there
12 wasn't a formal induction, there was opportunities for
13 me to learn what the roles and responsibilities of each
14 of the professions were and the opportunities and
15 challenges on the wards. 10:44
16 8 Q. And were you based at MAH five days a week or were you
17 else where and just came to MAH as and when needed?
18 A. No, I was based in MAH five days per week.
19 9 Q. Okay. You have referred to a number of senior staff in
20 paragraph six, are you able to say if some or all of 10:44
21 them had specific learning disability training as well
22 or experience in that field?
23 A. I'm not sure.
24 10 Q. You're not sure, okay. I want to move on to paragraph
25 six now and look at that in a bit more detail. 10:44
26 CHAIRPERSON: I'm so sorry, can I just check, the
27 statement that you're using, have you made notes on it?
28 A. I've just written down the names of the staff, there is
29 no other --

1 CHAIRPERSON: That's absolutely fine. Has anybody else
2 had any input into the notes you have made?
3 A. No.
4 CHAIRPERSON: That's fine, don't worry, thank you.
5 11 Q. MS. TANG: I want to talk a wee bit about the RQIA 10:44
6 improvement notices and the detail of those. You have
7 told us that there were three areas of focus, the first
8 of which was staffing issues. In paragraph 7 you use a
9 phrase which was, you referred to it as a "fragile
10 staff group". Can you say a bit more about why you 10:45
11 used the ward fragile?
12 A. I suppose when I arrived in Muckamore there had been a
13 significant number of staff either left or placed on
14 precautionary suspension. So there was a high usage of
15 agency staff that were mental health trained and 10:45
16 registered staff because there wasn't the supply of
17 learning disability staff either here locally or able
18 to be secured via the agency. So I suppose fragile in
19 the context of staffing levels were very tight, it was
20 a daily responsibility to try and ensure safe staffing 10:45
21 levels in each ward. Not all of the staff had all of
22 the experience, skills and qualifications that you
23 would want if you were providing the very best standard
24 of care. So there was a requirement to match the
25 available trained learning disability nurses with the 10:46
26 trained and registered mental health nurses and the
27 unregistered staff. The skill mix wasn't what you
28 would want for all of your wards in that there was
29 sometimes a higher level of untrained to trained staff,

1 which again makes safe staffing a challenge. And the
2 staff group were fragile in their kind of psychological
3 safety to be able to do their ward. There had been a
4 significant number of precautionary suspensions. The
5 staff were well aware that there was a live and ongoing 10:46
6 criminal investigation related to safeguarding
7 practices. There was ongoing CCTV reviewing, so you
8 could have been working today and then tomorrow either
9 been placed on precautionary suspension or on a
10 protection plan in relation to safeguarding. That 10:47
11 isn't an exemplar of psychological safety when you are
12 trying to manage patient care. And then there was a
13 number of staff that were wanting to leave. So again,
14 there was a fragility in having a stable, secure staff
15 group to deal with vulnerable patients. 10:47
16 12 Q. So a challenging environment?
17 A. It was very challenging for staff. There was the
18 absence then of management levels, as I have described
19 in my statement.
20 13 Q. Yes, I want to drill into that a wee bit further with 10:47
21 you just coming up shortly. I want to pick up on
22 something in paragraph 8 that you reference which was
23 the Telford exercise in relation to Belfast Trust. As
24 I understand it, we have heard evidence previously that
25 that was a model that was used to try and work out what 10:48
26 safe staffing levels should be in various areas?
27 A. So I am not a nurse by background, but my understanding
28 is that Telford is a standardised approach where
29 nursing staff are able to assess patient need, the

1 level and skill and numbers of staffing that is
2 required to meet that assessed patient need. So it was
3 a standardised model that was applied then in Muckamore
4 Abbey and it was being led centrally by the Corporate
5 Nursing Team in the Belfast Trust. 10:48
6 14 Q. So, was there at the end of that exercise an
7 understanding of how many skilled, how many registered
8 nurses, how many unregistered etc you needed depending
9 on the patient case mix?
10 A. There was. 10:48
11 15 Q. So you've mentioned that there was a high ratio of
12 unregistered staff in paragraph 8, was there a target
13 ratio that you were aware of as a result of that
14 Telford exercise?
15 A. There was a required ratio, so what safe care looked 10:49
16 like and that is what we were then trying to work on to
17 achieve. That was initially achieved via the agency
18 nurses being temporarily in the workforce and then it
19 moved on to a regional call to other Trusts to ask if
20 any learning disability nurses, or -- I think they 10:49
21 widened it out to mental health nurses were willing to
22 redeploy to Muckamore to achieve that targeted level.
23 DR. MAXWELL: Can I just ask, so did this exercise tell
24 you the numbers needed per shift or was it just an
25 establishment number for the numbers employed? 10:49
26 A. No, I think I recall it was down to each ward and
27 shift, so how many you would need on an a.m. or p.m.
28 DR. MAXWELL: So you might three registered nurses and
29 five healthcare assistants?

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1 A. Yes, both day and night because there was different.
2 DR. MAXWELL: Yes, so you had different numbers on each
3 shift. And you said that was initially met by using
4 agency nurses, but you've also said the agency nurses
5 were RMNs, registered mental health nurses, so I'm not 10:50
6 sure how that could have met the ratio?
7 A. So it met the ratio with staff in post, it didn't meet
8 the skill set ratio and that is where then they ask of
9 other Trusts to supply nursing staff came from.
10 DR. MAXWELL: The point I'm making is registered mental 10:50
11 health nurses are not the same as registered learning
12 disability nurses, so if the Telford exercise required
13 X number of registered learning disability nurses on a
14 shift and you were employing agency mental health
15 nurses who weren't meeting the requirement which was 10:50
16 for registered adult learning disability nurses?
17 A. So my recollection of the Telford exercise was that at
18 that stage a nurse was a nurse.
19 DR. MAXWELL: So it was a registered nurse, an
20 unregistered nurse rather than the skill set of the 10:51
21 registered nurse?
22 A. Yes. Then what you tried to do, once you had a
23 Registrant, was share the learning disability
24 experience as best that you could across the wards that
25 required that more than others. 10:51
26 DR. MAXWELL: Can I ask, the way safe staffing is
27 managed in England - sorry to use England as an example
28 - but there are these standards and Trusts are required
29 to publish the percentage of shifts that they met the

1 ideal staffing, do you have any idea of what percentage
2 of the shifts were meeting this standard that had been
3 set by the Corporate Nursing Team?
4 A. No.
5 DR. MAXWELL: You don't. To your knowledge that wasn't 10:51
6 collected?
7 A. It was maybe collected by either someone in the
8 nursing, Corporate Nursing Team, or, when H315 came to
9 Muckamore, I'm assuming that that's something that she
10 may have looked at. But my role in safe staffing was 10:52
11 for a short space of time. I don't know, no. But I'm
12 not saying it didn't happen, it is just in my short
13 space of time I wasn't responsible.
14 CHAIRPERSON: Can I just ask from a non-clinical view,
15 I know in some hospitals if they don't have sufficient 10:52
16 nurses to meet the required number, as it were, on a
17 ward, an incident would be declared or reported; if you
18 didn't have enough LD nurses on one of these wards, and
19 it sounds as if you often perhaps didn't, do we take it
20 no incident would have been declared? Do you know what 10:52
21 I'm talking about, first of all?
22 A. Yes. So I don't recall an incident having been
23 declared and I think -- to remember that there was such
24 a dearth of learning disability nurses available and
25 there was still 40 patients to be looked after. So my 10:53
26 recollection of the time was that, you know, we were
27 trying to get as many registrants as we could from a
28 skill set that whilst is not the same, there are
29 transferable skills to look after the patients. But

1 I don't recall a Datix incident form having been
2 completed if there was a lack of registered learning
3 disability nurses on a shift.
4 CHAIRPERSON: Okay, thank you.
5 DR. MAXWELL: Can I just follow up, did it get put on 10:53
6 the local risk register?
7 A. That wouldn't have been my responsibility. I suppose
8 H301 would have taken over that.
9 DR. MAXWELL: So you weren't involved in populating a
10 MAH risk register? 10:53
11 A. No.
12 DR. MAXWELL: Thank you.
13 PROFESSOR MURPHY: So was there a ban on admissions at
14 that time given all these staffing issues?
15 A. There wasn't a ban on admissions. I recall when I was 10:53
16 there, there were two times that there was a request
17 for admission. What would happen was, there was a Blue
18 Light meeting called, chaired by the Clinical Director
19 and attended by the community staff that would be
20 requesting the admission and the Muckamore staff who 10:54
21 would have been able to accept, potentially accept the
22 admission. One of those individuals was accepted to
23 the wards and the other one wasn't. So there has been
24 very few admissions to Muckamore Abbey Hospital for a
25 significant period of time. 10:54
26 PROFESSOR MURPHY: Thank you.
27 DR. MAXWELL: Sorry, just one more question about
28 staffing. So, clearly there was a problem with
29 staffing, RQIA had issued improvement notices, you

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1 yourself had observed there were problems. One of the
2 criticisms that is often made of quality improvement
3 exercises is they increase the bureaucratic tasks that
4 clinical staff have do and take them further away from
5 their patients. You go on to say about financial 10:55
6 management that a registered nurse had to check the
7 finance at the beginning and the end of every shift,
8 which sounds to me like a huge amount of a precious
9 resource spent on something that didn't require a
10 registered nurse. Was that ever considered? 10:55
11 A. Yes. So there was, I recall, a review of the financial
12 management procedures and I think the bureaucracy was
13 reduced, it wasn't taken away, but it was reduced from
14 the responsibility of the registered nurses. I can't
15 recall to what detail that was. 10:55
16 DR. MAXWELL: Okay, thank you. Sorry.
17 16 Q. MS. TANG: That's okay. You had made reference earlier
18 on to some calls out to other Trusts to try and bring
19 in staff whenever you were particularly short staffed,
20 would you say that other Trusts were not as badly 10:55
21 affected by learning disability nurse shortages as MAH
22 from what you could tell?
23 A. There was a lack of learning disability nurses across
24 Northern Ireland. I suppose the position of other
25 Trusts were they hadn't a significant number of their 10:56
26 staff either on sickness absence or precautionary
27 suspension relating to the circumstances that Muckamore
28 was experiencing. So there was an ask to share
29 resources or to, you know for staff in other Trusts to

1 come and do additional shifts in Muckamore, for
2 example, or, if there was capacity in that Trust, to
3 release the staff to redeploy to Muckamore for a period
4 of time, acknowledging that it was about managing a
5 finite resource. 10:56
6 17 Q. And were those calls generally successful or limited?
7 A. No, they were limited. There was financial enhancement
8 provided as an incentivisation for staff with learning
9 disability experience to come work in Muckamore. There
10 was some small uptake but it wasn't the numbers that 10:56
11 would have been required to deliver a very efficient
12 safe service.
13 18 Q. Would you, from what you could see whenever you came to
14 Muckamore first of all, had some of these staff
15 shortages been of long standing or were they all fairly 10:57
16 recent, the skilled nurses that you refer to?
17 A. My understanding is that there had been staff
18 shortages. There still are learning disability nurse
19 shortages and mental health nursing shortages in
20 Northern Ireland. It is an improving picture, but it 10:57
21 has been an historic pattern for a long time. So my
22 understanding is that there would have been shortages
23 as there would have been in any of the mental health
24 and learning disability wards in the Belfast Trust, it
25 was exacerbated just by the circumstances at Muckamore. 10:57
26 19 Q. Were you aware of any particular drives that had been
27 ongoing in Muckamore to try and attract more learning
28 disability staff maybe from overseas or whatever it be?
29 A. As I worked in Mental Health Services I had limited

1 interface with Muckamore prior to going on secondment,
2 so I wasn't aware of issues or of instances like that,
3 I'm not sure if they took place or not.
4 20 Q. Yes. Was it your sense that the Trust senior managers
5 above you had this very much on their radar, that they 10:58
6 appreciated just how significant the staffing pressures
7 were?
8 A. When I went to Muckamore, yes. But, as I have outlined
9 in my statement, it was a very flattened hierarchy and
10 it wasn't what I had been used to in experiencing. So, 10:58
11 sorry, I'm just looking for the cipher numbers. So
12 H296 and H394 were the two senior managers on the
13 Muckamore site who were responsible for Muckamore when
14 I arrived and they were very well aware of the nurse
15 staffing shortages. H394 had instigated, my 10:58
16 understanding was, the Telford Review exercise. Then
17 Francis Rice had been appointed by the Department of
18 Health to again provide assurance on nursing quality,
19 safety, numbers. We worked together on my early days
20 in Muckamore trying to stabilise the staffing group and 10:59
21 numbers and all of that process we've just described.
22 21 Q. You did make reference, as you've pointed out to us in
23 paragraph 7, about middle management and about the
24 management structure. The sense I get from your
25 statement is that there had been retirements et cetera, 10:59
26 and that these holes in the middle management structure
27 had appeared. Do you know how long those middle
28 management vacancies had existed?
29 A. I went to Muckamore in and around September of 2019,

1 having been interviewed in the August time. My
2 recollection is that there had been Co-Director
3 campaigns from around the Christmas time of 2018/2019,
4 so it was a number of months.
5 22 Q. I want to look at patient finances and the issue of 11:00
6 that. The improvement notice that was served in
7 relation to patient finances, how do you think the
8 problems around patient finances that you were there to
9 fix had come about?
10 A. So there were varied issues raised by RQIA in relation 11:00
11 to the improvement notices. One issue was that the
12 patients in their patient property accounts had accrued
13 a significant amount of money in that they were in
14 Muckamore for a long time, accruing some level of
15 benefit and not having the opportunity to spend the 11:00
16 money. There is a requirement by RQIA if you have a
17 figure, I think it's over £20,000 in your patient
18 property account, that that should be notified to RQIA.
19 That hadn't been happening at Muckamore. So one of the
20 issues was that we needed to understand how much money 11:01
21 patients had in their bank accounts. If you have more
22 than a certain amount, sometimes you have to repay
23 benefits, so there had to be a financial recalculation.
24 Then, obviously, patients need to spend their money on
25 things that either they need or they like and that was 11:01
26 part of the issue as well, about trying to help either
27 patients with the ability to do so or via their
28 advocates or families to make their life as full as
29 they could, purchasing items or trips or experiences

1 that they would benefit from. So that was one part of
2 the RQIA improvement notice. The other one was in the
3 actual day-to-day management. So if I purchase an
4 item, the receipt is provided, it's in line with my
5 wishes and needs and the right money in and out 11:02
6 happens, so that day-to-day procedural financial
7 control. Then I think there was also something about
8 in preparation for resettlement, how finances were
9 transferred to community services with the patient and
10 were also utilised to prepare for their resettlement in 11:02
11 line with what they wanted.
12 23 Q. So, were there issues whereby the staff who were
13 supposed to be doing these various procedures maybe
14 didn't have time to do them or didn't know what they
15 should do or what had to change? 11:02
16 A. Yeah. My recollection of it that, yes, there was a lot
17 of demands on staff, as we've briefly mentioned, and
18 the day-to-day financial procedures weren't as tight as
19 the policy suggested they could be and there was a lot
20 down to timing. The financial management procedures 11:02
21 appeared to be out of date and so staff were working to
22 things that they had always done as opposed to what was
23 useful for them. So there was a need for a review and
24 that is where the Finance Department in the Belfast
25 Trust took over responsibility to review the policies 11:03
26 and procedures. There also perhaps just wasn't the
27 awareness of spending money in line with the patient
28 need or want as much as there could be and that
29 attributed to the collection over the thresholded

1 amount. So it probably was a timing, a long standing,
2 just keep doing what they have always done and a policy
3 that needed to be reviewed.
4 24 Q. Thank you. I want to talk to you now about RQIA
5 safeguarding, the improvement notice on that. That's 11:03
6 picked up to some extent at paragraph 6 and then in
7 paragraph 15, and if we could turn to paragraph 15
8 please. You have indicated that there was a higher
9 degree of scrutiny of MAH at the time because of the
10 improvement notice, amongst other things, a requirement 11:04
11 to report every allegation against staff. Can you tell
12 me how did you ensure that the wards in MAH took a
13 consistent approach to what was reported?
14 A. So, the requirement to report to RQIA on a Form 2 came
15 probably a few weeks after I started at Muckamore. In 11:04
16 an attempt -- I suppose you can only report what's
17 reported to you. So, there was a lot of work being
18 done by the adult safeguarding DAPOs to help ward staff
19 understand what potentially could be a safeguarding
20 issue and, if there was a concern from a safeguarding 11:04
21 perspective, what to do about that and what forms to
22 fill in and who to record. So there was an attempt to
23 change the culture or be more aware and open to
24 reporting.
25 11:05
26 There was the introduction of the live governance
27 system, as I refer to in the statement, led by the
28 Clinical Director on a weekly basis and there was a
29 requirement for ward managers to bring to that meeting

1 the level of incidents, the numbers of self injurious
2 behaviour as well as some of the detail, the numbers of
3 restrictive interventions, the numbers of PRN
4 medications given out. So there was a focus on trying
5 to bring data that allowed further questioning to come. 11:05
6
7 So in response to your queries, there was work ongoing
8 to try and help staff on the ground recognise
9 safeguarding issues. There was a requirement and an
10 accountability mechanism on a weekly basis where those 11:05
11 were reviewed and then there was the ongoing
12 contemporaneous CCTV reviewing. So the reviewers
13 looked a week or two back, and again that provided
14 opportunities for further questioning and curiosity.
15 25 Q. Where you were still receiving allegations of staff on 11:06
16 patient safeguarding issues, were you able to review
17 those particular circumstances on CCTV?
18 A. So I didn't review those. If there was a staff on
19 patient allegation, that moved directly into adult
20 safeguarding and the DAPOs would have taken that over. 11:06
21 26 Q. Can I ask, if you are able to tell me, what the
22 physical resources in relation to CCTV viewing were,
23 were there rooms set aside?
24 A. There was one room set aside at the end of the
25 administration corridor in the main admin building. It 11:06
26 was a locked room. There was a computer that linked in
27 to all of the CCTV cameras that were available on the
28 ward that you could retrospectively play back. Then
29 CCTV evidence could be downloaded as required on

1 request via an external company.

2 27 Q. Yes. You have mentioned that external reviewers were
3 brought in to look at CCTV, do you know if any of these
4 were former MAH staff?

5 A. No, and I suppose they were external in the context 11:07
6 that they hadn't worked in Muckamore Abbey Hospital
7 before.

8 28 Q. Okay, thank you.

9 A. They were, in the main, retired Belfast Trust employees
10 from other services, but my understanding was that they 11:07
11 hadn't worked in Muckamore Abbey.

12 29 Q. Okay. Just the last point on CCTV, were you aware of
13 any tensions between the HR team and the safeguarding
14 teams and the PSNI?

15 A. No. 11:07

16 30 Q. None?

17 A. I wasn't aware of any tensions. Safeguarding
18 historically was managed off the Muckamore Abbey site
19 and I would have had no interaction with the historical
20 review of CCTV. The contemporaneous review of CCTV, if 11:08
21 there was an issue that had been raised from a training
22 or safeguarding perspective, that was dealt with
23 locally by the DAPO with HR guidance. But I had no
24 awareness of that. There were some difficulties when
25 I arrived in Muckamore in the interface with the PSNI 11:08
26 but it was the timeliness of providing information that
27 was required for the purposes of their investigation
28 and that is where I tried then to link with the PSNI to
29 establish the due process for the provision of Form 81s

1 and then the subsequent information from there, but
2 that's my only awareness of tension.
3 MS. TANG: Okay, thank you.
4 CHAIRPERSON: Are you moving on from CCTV?
5 MS. TANG: Yes, I am. 11:08
6 CHAIRPERSON: Could I just ask a few questions around
7 that and then we might take a break because you have
8 been going about an hour. You say that you were
9 responsible for organising the contemporaneous CCTV
10 reviewing, so can I just ask this: You say there was a 11:09
11 random selection to be reviewed, whose decision was it
12 that it should be done randomly and why?
13 A. So the policies and procedures were already established
14 when I arrived in Muckamore. Because I was only there
15 for a very short space of time and there was a lot to 11:09
16 do, so I didn't have time to review everything that you
17 would maybe like to do in detail. So there was a
18 decision made that there was a random selection of
19 shifts so that it wasn't always day-time shifts that
20 were reviewed or night-time shifts or weekend shifts, 11:09
21 so there was a random selection of days, nights,
22 weekends.
23 CHAIRPERSON: Night-time shifts were reviewed, were
24 they?
25 A. Yes, during my time of setting out the schedule. So 11:09
26 you would have set out days and times, so 6:00 pm to
27 midnight, you know, 2:00 am to 6:00 am, Saturday
28 mornings. So you did a random.
29 CHAIRPERSON: Right. And schedules were obviously kept

1 of what was reviewed?
2 A. My understanding -- well when I was there they were all
3 in a folder in the CCTV room, yep.
4 CHAIRPERSON: And were you aware of there being
5 different phases to the watching of CCTV? 11:10
6 A. In relation to the historical CCTV reviewing?
7 CHAIRPERSON: Yes.
8 A. Yes. But I suppose this was the contemporaneous CCTV
9 reviewing, so this was the week prior.
10 CHAIRPERSON: No, I understand. 11:10
11 A. But I was aware that there were different phases and
12 different wards being reviewed, yep.
13 CHAIRPERSON: And just finally this: So far as you
14 were concerned, relations with PSNI in relation to your
15 function were always good? 11:10
16 A. Well, as I've said before, I remember when I first went
17 to Muckamore there were some tensions with PSNI in the
18 timeliness of providing information to the police in
19 relation to their criminal investigation. I recall
20 meeting with PPU in Antrim Road Police Station to try 11:11
21 and ascertain what their expectations of the Trust
22 were. There were a number of outstanding Form 81s that
23 had been submitted for staff training records,
24 inductions et cetera, et cetera. So one of my roles,
25 as noted in my statement, was to try and expedite that 11:11
26 and get a smoother more timely system in place which,
27 by the end of my time there, that was in place. That
28 was my only experience of interaction with the PSNI and
29 the only tension in that was the timeliness of

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1 providing the information.
2 CHAIRPERSON: All right. We'll take a short break,
3 about 15 minutes. And you've probably got about 20
4 minutes, half an hour to go?
5 MS. TANG: At most, Chair, at most. 11:12
6 CHAIRPERSON: Okay. Thank you very much.
7
8 THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS
9 FOLLOWS:
10 11:31
11 CHAIRPERSON: Thank you.
12 31 Q. MS. TANG: Thank you, Chair. Ms. McGall, I've just got
13 a couple more things I want to deal with. I want to
14 ask you some questions about PRN and restrictive
15 practices and then a short little thing I want to 11:35
16 clarify with you from evidence given earlier.
17
18 Can I take you to paragraph 19 of your statement,
19 please. I note from that, that you mentioned there was
20 some trend analysis review in relation to restrictive 11:35
21 practices. Can you recall was the trend downwards?
22 A. Yes. So there was a data set, a minimum data set that
23 was required to be populated by the Ward Managers and
24 then presented at that weekly live governance meeting.
25 The information provided then was analysed by the 11:36
26 Planning Performance Team in the Belfast Trust. My
27 recollection was that there definitely was a downward
28 trend in relation to seclusions and the upper limits of
29 restrictive interventions. I can't recall specifically

1 about PRN medication, although I do know one of the
2 consultant psychiatrists responsible for the female
3 ward - their name is not mentioned there - but they
4 were looking at a specific piece of work on PRN
5 medication, so I'm sure that information could be 11:36
6 provided by Belfast Trust.
7 DR. MAXWELL: Can I ask about that, because, yes, there
8 was the performance team looking at population trends,
9 but certainly in the MDT meetings I would have expected
10 the team to look at the trends for individual patients, 11:36
11 so was there a particular activity that triggered
12 certain behaviours that led to these practices. I have
13 to say we have seen some of the PDRs and I think there
14 are some trends for some patients, do you know if that
15 was ever discussed at a clinical level? 11:37
16 A. So my understanding -- the piece of quality improvement
17 work that I just mentioned there led by one of the
18 psychiatrists in the female ward was very much aligned
19 with individual patients.
20 DR. MAXWELL: But to your knowledge did they actually 11:37
21 look at it and say 'this patient has a lot of MAPA
22 holds, shall we do a deep dive and see if we can
23 understand why this is happening'?
24 A. I wasn't involved in clinical meetings in my short time
25 in Muckamore, so I couldn't say for sure that that 11:37
26 happened at every clinical meeting. I know there was a
27 specific project under way in the female ward which may
28 be aligned to what you are suggesting, but I'm not sure
29 if it was broad scale across all of the wards.

1 DR. MAXWELL: Thank you.
2 32 Q. MS. TANG: Staying in paragraph 19, you had made
3 reference to being notified of certain usages of
4 restrictive practices, I think on that occasion you
5 were talking about seclusion, it's about two thirds of 11:38
6 the way down that paragraph. Can you just let me know
7 what were the notification processes for the use of
8 that practice whenever you were there?
9 A. So there was a policy which was being reviewed as well.
10 My recollection was that obviously seclusion was 11:38
11 decided upon by the MDT or the team that was present
12 with the patient. Once the seclusion had been
13 initiated there was a discussion with the medic to
14 understand why seclusion had to take place and the time
15 that it started and they also had to review the patient 11:38
16 post seclusion. Then there was an escalation to the
17 operational management on site which at that space of
18 time was me, to let me know that seclusion had
19 commenced, the reason for the seclusion, the location
20 of the seclusion, the staff who were aligned to be on 11:39
21 obs with the patient in seclusion and the current
22 status of the patient. Then once seclusion was
23 concluded you got another call to let you know that
24 seclusion had concluded, how the patient was and either
25 the medic had reviewed post seclusion or was due to 11:39
26 review.
27 33 Q. Do I understand you correctly, this was the new
28 procedure or this was the old procedure that continued?
29 A. This was the procedure that was in place when I was in

1 Muckamore, I can't speak for what went before.
2 34 Q. Did you bring in this procedure?
3 A. No, it was established when I arrived there.
4 35 Q. It was established, okay. You had told us that you
5 attended on the two occasions that you were notified 11:39
6 about, was there any particular reason why you did
7 attend on those two occasions?
8 A. I hadn't observed seclusion in learning disability
9 before nor had I observed it in Mental Health Services.
10 So I wanted to see what it was like, I wanted to 11:40
11 understand the set-up, I wanted to see how the patient
12 was presenting, I wanted to understand what staff
13 support was around for that patient and what the
14 policies and procedures and interactions on the ground
15 were like, so I wanted to check out for myself what it 11:40
16 looked like.
17 36 Q. Okay, thank you.
18 CHAIRPERSON: Could I just ask about your last answer,
19 that obviously seclusion was decided upon by the MDT.
20 I don't quite understand how that would work. If a 11:40
21 patient is in such a state that they may need
22 seclusion, how do you get an MDT together to make a
23 decision on -- am I misunderstanding what you're
24 saying?
25 A. No, I suppose MDT is maybe a stretch of the term in 11:40
26 that the nursing and non-registrant staff that were
27 present.
28 CHAIRPERSON: Yes, exactly.
29 A. Sometimes the medics were on the ground, therefore

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1 there was the opportunity to discuss. But it wasn't a
2 care planned MDT decision because, obviously, seclusion
3 is a reaction to an emergency event.
4 CHAIRPERSON: Exactly.
5 DR. MAXWELL: My understanding is that the MDT would 11:41
6 decide that seclusion might be needed and then it was
7 applied according to the discretion of the nurse in
8 charge when the patient's behaviour warranted it but
9 the decision --
10 A. To seclude is the nurse. 11:41
11 DR. MAXWELL: -- that seclusion could be used would
12 have been made in advance at the MDT meeting, is that
13 your understanding?
14 A. So seclusions happen very rarely. My recollection of
15 the times that I saw seclusion was that there had been 11:41
16 a history of requiring seclusion which is discussed at
17 an MDT level.
18 CHAIRPERSON: Right. So we will see that in the MDT
19 notes.
20 A. So it could potentially have been in a restrictive care 11:41
21 plan that seclusion was required for this individual.
22 The decision to seclude at that moment in time is the
23 nursing and non-nursing team on the ground.
24 CHAIRPERSON: Yes, I can understand that, but that is
25 sort of a policy decision in relation to that for that 11:42
26 patient, but obviously the team who is looking after
27 the patient at the time has to decide whether seclusion
28 is necessary or not?
29 A. Yes.

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1 CHAIRPERSON: In accordance with the decision of the
2 MDT?
3 A. Yes.
4 CHAIRPERSON: All right, that's how it works, thank
5 you. 11:42
6 37 Q. MS. TANG: Thank you. I wanted to just clarify
7 something that we had covered slightly earlier and that
8 was whenever we were talking about Telford nursing,
9 staffing reviews. Can I just be clear that Telford
10 would tell you whether or not you had enough mental 11:42
11 health registered nurses but not LD particularly?
12 A. So my understanding and recollection of the Telford
13 that went on at Muckamore was about registrants and
14 non-registrants.
15 38 Q. So it didn't? 11:42
16 A. It didn't differentiate at the highest level between
17 the category of registration of the nurses. So it was
18 about securing registrants and non-registrants. Then,
19 based on the needs of the patient - and I suppose we
20 have to remember the majority of these patients should 11:43
21 have been resettled - so the level of significant
22 nursing intervention, whilst still a hospital, wasn't
23 always present. Then Telford looked at where the
24 learning disability needs, nursing needs of the patient
25 lay and then you had to try and match the staff to 11:43
26 that.
27 39 Q. So did Telford tell the wards in simple terms how many
28 learning disability registered nurses they needed in
29 MAH?

1 A. Yes.
2 40 Q. It did. And was there a --
3 DR. MAXWELL: Can I just clarify, what you said is
4 Telford tells you how many registered nurses you need,
5 it didn't tell you how many learning disability nurses 11:43
6 you need?
7 A. Again I wasn't actively involved in Telford.
8 DR. MAXWELL: These are questions we should put to
9 Corporate Nursing.
10 A. To nursing, yes. My recollection was that, at the 11:44
11 broadest level, the Telford exercise looked at
12 registrant verse non-registrant but there was an
13 understanding, obviously you need to have your
14 registrants trained and skilled to treat the population
15 for whom you're serving and that is where the 11:44
16 application came in about how many learning disability
17 nurses versus how many mental health nurses. What that
18 looked like on the Telford schedule I'm not sure, and
19 that is a discussion for the Corporate Nursing Team,
20 but at the highest level it was registrants and 11:44
21 non-registrants and then there was the applicability of
22 the qualification to do that.
23 MS. TANG: Thank you. Chair, Panel, those are all my
24 questions for the witness, unless the Panel have
25 everything they wish to follow up. 11:44
26 CHAIRPERSON: Yes. Professor Murphy?
27
28 MS. JAN McGALL WAS THEN QUESTIONED BY THE PANEL,
29 AS FOLLOWS:

1
2 41 Q. PROFESSOR MURPHY: Could I ask you a little bit about
3 contracts for staff because, from what you're saying
4 there was very clearly a staff shortage. We've heard
5 from other witnesses that one of the reasons for that 11:45
6 was that temporary contracts were all that was being
7 offered at Muckamore at certain stages because of the
8 pressure to resettle. Was that the case when you were
9 there?
10 A. So I'm not aware what went before I arrived in 11:45
11 Muckamore. It was not an issue when I was there.
12 There would have been a requirement to recruit on a
13 permanent basis. So it wasn't an issue when I was
14 there, but I can't speak for what went before.
15 42 Q. PROFESSOR MURPHY: Okay, thank you. And I have got one 11:45
16 other question which was about the pods on Erne that
17 you describe in paragraph, I think, 14. We've heard
18 about these from some other witnesses as well, I wonder
19 if you would tell us whether you had seen the pods
20 yourself, what your view was about their 11:45
21 appropriateness?
22 A. So, when I heard about pods I guess I had an idea in my
23 mind, but when you visited the ward actually it just
24 was an area marked out for that patient within a warden
25 environment, so it wasn't a specific -- 11:46
26 43 Q. DR. MAXWELL: Structure?
27 A. -- structure, no. It was just that the patient had
28 that wing of the ward or those four rooms. My
29 understanding was that there had been a

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1 multidisciplinary care plan decision based on the needs
2 of the patient and their ability to live with others or
3 interact with others. When I went to Muckamore they
4 had been established for a very long time specifically
5 on Erne Ward, so there was no new decisions to erect 11:46
6 pods when I was there.
7
8 My own reflection on them were that it was a very
9 solitary existence. Sometimes that did meet patient
10 need dependent on their presentation, but there was 11:47
11 still a requirement to ensure that there was
12 interaction with others, whether that be that there was
13 defined staff all of the time or they were able to
14 engage in, you know, periodic time with peers in
15 purposeful activity as opposed to living with them all 11:47
16 of the time.
17 44 Q. DR. MAXWELL: And did you talk to people who were
18 living in these pods to see what they thought of them?
19 A. So I had some engagement with the patients,
20 particularly on Erne ward. Their level of interaction 11:47
21 with me was quite limited and it probably was I was
22 there for a short space of time, I was very new to
23 them. So beyond pleasantries, saying hello, they
24 didn't engage much with me and I didn't have the
25 opportunity because I wasn't there long enough to 11:48
26 engage more fully with them.
27 45 Q. DR. MAXWELL: You didn't have an opportunity to discuss
28 it with families at all?
29 A. I didn't have an opportunity to discuss it with

1 families. As I say my recollection was that the pods
2 were in existence for a significant period of time
3 prior to my commencement at Muckamore. Because I was
4 there for such a short space of time and there was
5 quite a lot to do, my involvement with families was 11:48
6 very minimal. I do know that when H301 and H315 joined
7 Muckamore they had a significant amount more engagement
8 with families and there was a carer advocate at that
9 time or a carer consultant had been appointed who would
10 have engaged with families. So it wasn't really within 11:48
11 my role to be engaging directly with families, it was
12 for others to do.
13 DR. MAXWELL: Okay, thank you.
14 46 Q. PROFESSOR MURPHY: Yes, just back to staffing again.
15 So you talked about the sources of nurses, but by the 11:49
16 time you went to Muckamore this was a very complex
17 group of patients who needed a multidisciplinary input,
18 were there sufficient OTs, physios, behaviour support
19 staff, was it just nursing that there were shortages
20 of? 11:49
21 A. No, there hadn't been -- so obviously being an
22 occupational therapist I was aware of the extent of the
23 provision across the Trust. Muckamore hadn't had OTs
24 for many years and then they had been introduced
25 several years before I arrived in Muckamore. So there 11:49
26 were OTs present on site when I was there. I think
27 I recall two or three. There probably was the need for
28 more if we were trying to enhance the multidisciplinary
29 team.

1 47 Q. DR. MAXWELL: So in an ideal world there would have
2 been more OTs to prepare for resettlement?
3 A. Absolutely, and ward aligned as opposed to responding
4 to need. I can't recall if there were physios when
5 I was on site, but I do know they had been present in 11:50
6 Muckamore for many years prior to OTs being on the
7 site. There was no dietetics as I recall. There was a
8 behaviour support team, and I met with one or two of
9 them, they were more aligned to psychology. Again
10 there had been staffing interruptions to that team. 11:50
11 I'm not sure of the reason, if it was sickness, absence
12 or precautionary suspension. But again if you are
13 thinking about resettling and change and preparing
14 parents for something new, you would have wanted a
15 robust positive behaviour support team to prepare both 11:50
16 the patient and the provider who would be accepting
17 them.
18 48 Q. DR. MAXWELL: And so, do you think that - so we know
19 that there was a shortage of learning disability
20 registered nurses - do you think that the problem with 11:51
21 OTs, which you know best, is a lack of supply or that
22 the Trust hadn't funded the right number of posts to
23 meet the patients' needs in an ideal world?
24 A. It is probably about the allocation of funding.
25 49 Q. DR. MAXWELL: Funding. So the Trust hadn't funded 11:51
26 sufficient posts?
27 A. Or the Trust hadn't been commissioned to provide
28 sufficient numbers of posts.
29 50 Q. DR. MAXWELL: Whoever provides the funding hadn't

1 thought about and provided sufficient funding for the
2 optimum number of occupational therapists?
3 A. Yes. And I suppose it's across the range. You know,
4 there was a lot of physical health needs of the
5 population of Muckamore. So there had been some 11:51
6 investment to bring in a GP with specialist interest in
7 learning disability to look at the physical health
8 needs. But it wasn't a robust multidisciplinary team
9 with the scale and spread that you would want for the
10 population that was on Muckamore site, especially in 11:51
11 the preparation for resettlement.
12 DR. MAXWELL: Thank you.
13 CHAIRPERSON: Right, well thank you very much. What
14 I've got to ask is purely administrative, it is just
15 this: When you came to the Inquiry you had your 11:52
16 original statement with the names on it and then you've
17 written in the ciphers, have you.
18 A. Mhm-mhm.
19 51 Q. CHAIRPERSON: Can I ask when you wrote the ciphers in?
20 A. Just prior to coming into the Inquiry today. 11:52
21 52 Q. CHAIRPERSON: So once you had the Inquiry statement?
22 A. Yeah, yeah.
23 CHAIRPERSON: Okay. Would you mind, I am going to ask
24 you to leave your notes and your statement so that can
25 be shredded, only because we are trying to limit, as 11:52
26 far as possible, written documents that have the cipher
27 list on them. Can I thank you very much for coming to
28 assist us. I don't think we are going to have you back
29 again. If we do, you will be very welcome, but if you

1 could leave your notes with Jaclyn. Thank you very
2 much indeed. No-one will look at it, we don't want to
3 see your personal notes, we just want to shred it.
4 A. Okay.
5 CHAIRPERSON: Ms. Tang, where do we go now? 11:53
6 MS. TANG: Yes, thank you, Chair. Following the
7 evidence of Ms. McGall we have two statements that are
8 to be read into evidence. The next evidence that you
9 will receive will be from the same witness, named Paula
10 McCann, and there will be an application for a 11:53
11 Restriction Order.
12 CHAIRPERSON: Are you dealing with those?
13 MS. TANG: Yes, I am.
14 CHAIRPERSON: Okay. I think there is an application
15 for Restriction Order in relation to a statement that 11:53
16 she produces --
17 MS. TANG: Yes.
18 CHAIRPERSON: -- which she originally wrote for the
19 PSNI.
20 MS. TANG: That's correct. 11:53
21 CHAIRPERSON: So I'll make a Restriction Order in
22 relation to the application to preserve the position,
23 if the feed is working to Room B it can be cut, and the
24 stenographer knows how to treat this? Yes.
25 11:54
26 RESTRICTED SESSION.
27
28
29 THE INQUIRY CONTINUED IN OPEN SESSION.

1
2 MS. TANG: Yes, okay, thank you. The first statement
3 in that case that I am going to read in is statement
4 reference STM-197, and it is the statement of Paula
5 McCann which is dated 26th of January 2024: 12:00
6
7 "I, Paula McCann, make the following statement for the
8 purpose of the Muckamore Abbey Hospital Inquiry.
9 This is my second statement. The first statement..."
10 12:00
11 And she gives the date of the previous one:
12
13 "My connection with MAH is that I was a temporary
14 health care worker at MAH Band 3. The relevant time
15 period that I can speak about is between June 2013 and 12:00
16 November 2014. I wish to add the following further
17 information to my first statement.
18
19 I currently work for Inspire, a supported housing
20 scheme as a senior project worker and I am the 12:00
21 assistant manager. I have a degree in Psychology and a
22 Masters Degree in Applied Psychology, Mental Health and
23 a Psychological Therapies. I do not have any
24 qualifications or training in learning disability.
25 12:01
26 After completing my studies I was looking for a
27 relevant health care post to start my career.
28 I applied for the role of Health Care Assistant at MAH.
29 I recall that I was interviewed for the position and

1 started employment at MAH shortly afterwards. I do not
2 recall the specific details of the recruitment process.
3 I began employment at MAH in June 2013. I was on a
4 temporary, month-to-month contract for most of my
5 employment but I worked full-time hours. I think that 12:01
6 I may have received a six month contract towards the
7 end of my employment but I cannot recall.
8
9 I went on sick leave due to stress in November 2014 and
10 I handed in my notice in January 2015. I did not go 12:01
11 back to work in MAH after November 2014. I recall that
12 I had worked at MAH for several months before
13 I conducted my formal induction training. This took
14 place at Musgrave Park Hospital in Belfast with a group
15 of health care workers from across the Belfast Health 12:02
16 and Social Care Trust, the Belfast Trust. The training
17 included basic nursing training such as first aid, but
18 I cannot recall the specific details.
19
20 I was employed by MAH from June 2013 to January 2015. 12:02
21 I initially worked on the Oldstone ward and moved to
22 ward four, Moylena, in November 2013. The patients in
23 Oldstone were very independent and lived in shared
24 houses. This was a transition ward from the hospital
25 environment back into the community. I worked on 12:02
26 Oldstone for approximately six months. It was a lovely
27 place to work and I liked it a lot. Staff were
28 assigned to different houses on a daily basis. On
29 arrival for my shift, I went to the office, looked at

1 the daily allocation sheet, found my name and where
2 I was allocated for the day. The nurse in charge
3 assigned for that particular day handled the allocation
4 sheet. I cannot recall if there was a handover of
5 patients between shifts. I may have had responsibility 12:03
6 for four or five patients in a house or I could have
7 been allocated on a one-to-one basis with a patient.
8 I was responsible for getting the patients up and
9 dressed, making sure they had breakfast and other
10 meals, taking them to Occupational Health or their 12:03
11 placements, taking them shopping or any other
12 activities. I enjoyed my time in Oldstone. The
13 patients seemed very happy and I do not recall any
14 incidents happening during my time working in Oldstone.
15 12:03
16 After approximately six months, I moved to M4 ward.
17 The patients on M4 ward were all male. They had severe
18 learning disabilities and most were non-verbal. At the
19 start, I was working with other competent members and
20 I liked the ward. Some of the members of staff who 12:04
21 worked with me were H118, H816, H817 and H114.
22 I worked day shifts, which usually started at 7.30 in
23 the morning to around 2.30 in the afternoon. I checked
24 the allocation sheet in the morning in the office and
25 I made my way upstairs to the dormitories. M4 was a 12:04
26 dormitory style layout with a communal room in the
27 middle used for staff handovers and two dormitories
28 leading off the communal area.
29

1 There was usually a handover in the morning from the
2 night staff who would report any incidents that
3 occurred during the night, for example if someone had
4 not slept well. There were not any particular
5 incidents reported to me on handovers that stand out to 12:04
6 me.
7
8 I may have occasionally been asked to provide relief
9 cover to other wards. This was usually communicated in
10 the daily allocation sheet or sometimes a nurse may 12:04
11 have come onto the ward to ask me to provide temporary
12 relief for the day. This could have been to Cranfield
13 ICU, Cranfield women's ward, Ennis, Erne or Killead.
14 I found the atmosphere on these wards to be good and
15 that the staff were all well supported. 12:05
16
17 Over a short period of time on M4 ward it seemed as
18 though there were less and less staff on the ward to
19 care for the patients. There seemed to be a staff
20 shortage and I felt it was becoming dangerous. 12:05
21 I cannot recall if I reported my concerns to anyone at
22 this time but I may have done. I do not know why there
23 were staff shortages. When there were more staff at
24 the start myself and the other staff were able to
25 engage more with the patients and I would take the 12:05
26 patients out for walks. When there were fewer staff
27 there was less engagement with the patients and I was
28 not able to go anywhere or take them out as it was not
29 safe to do so. Risk factors could have included

1 absconding, physical assault to others or towards
2 themselves, slips, trips or falls. This could not have
3 been managed if I had been by myself with possibly
4 another three or four patients that I was responsible
5 for, all who would have been severely autistic and 12:06
6 unable to understand different situations. I think
7 this was a contributing factor to the patients becoming
8 agitated as they were in the same room all day.
9 Sometimes I could have been on my own on the ward and
10 I had to cope with five or six patients. This depended 12:06
11 on staffing allocation for the day. Sometimes there
12 were two members of staff in each day room, other times
13 there was only one. I do not know the reason for this.
14 The patients were all male and were bigger and stronger
15 than me. They could be aggressive at times. 12:06
16
17 One particular incident was very upsetting for me.
18 I cannot recall the specific date on which it occurred.
19 I was on my own on M4 ward in the middle day room. A
20 male patient, who was larger and stronger than me, 12:07
21 pulled me by the hair and had me locked facing down.
22 I was trying to hold his hands from pulling my hair out
23 so I could not press the assistance button or sound the
24 alarm. There was no-one else on the ward to see what
25 was happening and to assist me. It was very 12:07
26 frightening. There were five or six patients in the
27 day room at the time. After about two minutes the
28 patient let go of my hair and I managed to press the
29 button for assistance which beeps through to the

office. The office was located at the entrance to the building. Access to the day rooms was through a door that was operated with a key fob that staff members had. The nurse in charge came out and asked if I was okay. The nurse in charge that day was from another ward, possibly on relief but I'm not sure. I cannot recall her name. I cannot recall exactly what I said but then she went back into the office. I was shaken as the patient had pulled a large clump of my hair out. I was not asked if I was able to continue with my shift or even if I needed to take a break for a cup of tea. I'm unsure if an incident report was completed. The nurse in charge went back to the office and I had to continue with my shift.

This incident was a month or two before my wedding in December 2014 and on my wedding day I had a bald patch on my head. I am now in a managerial position and I would never treat staff this way. I would give them the choice to go home if this happened. I learnt a lot from this experience on how not to manage staff. There are several other similar incidents like this that happened to me at MAH but it is too upsetting to recall them all and I do not wish to relive them.

During my time on M4 ward I witnessed many examples of good care of patients. The staff were largely very committed and provided good care to the patients. On one occasion, I cannot recall the date, I witnessed a

1 male patient who was extremely agitated and was a
2 danger to himself and others around him. H270 and H355
3 used MAPA restraint policies as a last resort to deal
4 with the patient in a non-aggressive way. They treated
5 the patient with compassion, talked to him reassuringly 12:09
6 and managed to de-escalate the situation very quickly.
7 I was very impressed with how they handled the
8 dangerous situation."
9 We then come to some paragraphs that are restricted
10 where I will just refer to the patient giving some 12:09
11 details of an incident and an individual.
12
13 I will move on to the last sentence of paragraph 18.
14 CHAIRPERSON: The first -- are you not dealing with the
15 first sentence of paragraph 18? 12:09
16 MS. TANG: Sorry, my apologies, Chair, I have lost my
17 place, yes the first sentence of paragraph 18:
18
19 "The formal reporting and complaints process was never
20 explained to me either during my induction or 12:10
21 otherwise. If I needed to report anything, it would
22 have been done informally with my manager, H270. I did
23 initially feel that I could report anything to him."
24
25 And moving on then: 12:10
26
27 "However, after an incident I felt that I was judged
28 and isolated by other staff and I did not feel
29 comfortable to raise any further issues. I did not

1 have any other complaints to raise.
2
3 In general I do not feel that I was well supported
4 during my employment at MAH. I feel that I was thrown
5 in at the deep end and just expected to get on with 12:10
6 things. By this I mean that I had very little
7 induction training or shadowing with more senior and
8 experienced staff.
9 I had very little information about patients. The only
10 way I received information about patients was by asking 12:11
11 other staff members. Health care support workers did
12 not have access to the patients notes, only the nursing
13 staff. Support workers did not have time to go on the
14 computers. We were allocated to care roles and not
15 office based. I cannot remember ever seeing a support 12:11
16 or care plan, they were not available to support
17 workers. I did not have any information from families
18 about a patient's daily routines and in my current role
19 we make sure that there are alert pages on the front of
20 the patient's file and that all staff have access to 12:11
21 this information. I would not have been aware of a
22 patient's skills prior to admission and what they
23 needed help with. However, by working with the
24 patients I developed an understanding of their likes
25 and dislikes, for example whether they liked to do 12:11
26 jigsaws or whether they liked to have baths. I learned
27 information from other staff members as well about a
28 patient's challenging behaviours, but you were expected
29 to learn on your feet. I had no involvement in patient

1 care plans and I did not see these. I do not know what
2 treatment plans the patients had but other staff on the
3 ward would have told me that certain patients could be
4 aggressive or that certain patients were on a liquid
5 diet. You learn a patient's vulnerabilities when 12:12
6 working with them every day and you do not forget.
7 I learned ways of working through my own experiences
8 and also what other staff members would advise me or
9 information that they would give me. Meal times were
10 supervised. Staff would have been in the dining room 12:12
11 with the patients that they were allocated to on that
12 shift.
13
14 I did not have any training in restrictive practices.
15 If a patient was distressed, they were managed by 12:12
16 trying to de-escalate the situation. I knew what the
17 patient liked or did not like, what worked and what did
18 not work. I would take the patient for a walk or take
19 them for a bath. If a patient remained agitated,
20 I pressed the buzzer for assistance and a nurse may 12:13
21 have administered medication to help. I cannot recall
22 how often this happened. There was one patient who
23 always pulled his trousers down and a belt was placed
24 at the back of his trousers to prevent this and protect
25 his dignity. I cannot recall the full details 12:13
26 surrounding the use of the belt, but I recall being
27 told - I cannot recall from whom - that the consultant
28 had agreed to this. There was no seclusion room on the
29 M4 ward.

1

2 The nursing staff would have conducted a ward round and
3 asked how everyone was doing but they were not on the
4 ward a lot. There was a registered nurse on the ward,
5 usually in the office, but I did not have any meetings 12:13
6 with them routinely. I would have reported anything to
7 them if there was a concern about a patient.
8
9 I did not have anything do with patient admissions and
10 I was not informed of the purpose for patient 12:13
11 admissions. I had very little interaction with family
12 members. Family visits for patients on the M4 ward
13 took place in a meeting room which was off the ward and
14 beside the office. If a family member came to visit, a
15 nurse might have come and told me and I would bring the 12:14
16 patient to the door. The nurse would then take the
17 patient to the meeting room.
18
19 I had no involvement in the planning for a patient's
20 discharge and resettlement and I had no specific 12:14
21 resettlement training. However, I may have been told
22 that a patient had been allocated a place in the
23 community and I would have assisted in familiarisation
24 visits with other staff members and the patient. I was
25 not involved in this process in any other way. 12:14
26
27 I went on sick leave due to work-related stress in
28 November 2014. There were several contributing
29 factors, one of which was the other staff ostracising

1 me after reporting an incident. I felt that there were
2 fewer staff on the ward, so it felt dangerous to me.
3 I also wanted to leave the role to progress my career
4 in mental health as this is what I had trained in.
5 12:15
6 There are no other incidents that I wish to report."
7
8 The witness then goes on to indicate her wishes around
9 giving evidence, and she provides a declaration of
10 truth. The statement is signed and dated on 26th of 12:15
11 January 2024.
12 CHAIRPERSON: Okay. So that deals with the public part
13 of that statement and now we need to go to the
14 restricted part.
15 MS. TANG: Yes. 12:15
16 CHAIRPERSON: So the feed to Room B should be cut,
17 please.
18
19 RESTRICTED SESSION.
20 12:15
21
22 THE INQUIRY CONTINUED IN OPEN SESSION.
23
24 MS. BERGIN: Thank you, Chair. Good afternoon, Chair
25 and Panel. The next statement is that of A6, statement 12:27
26 reference STM-201. And, as you've indicated, Chair,
27 there is an Anonymity Order that you already granted in
28 respect of this witness' evidence on 16th January 2024.
29 But, there are no other Restriction Orders.

1
2 Chair, I should say that, in light of the Anonymity
3 Order, there are parts of this statement that I'm
4 reading aloud that I may summarise or I may use an
5 alternative word, just to draw that to everyone's 12:27
6 attention.
7 CHAIRPERSON: Sure.
8 MS. BERGIN: Statement dated 9th February 2024:
9
10 "My connection with MAH is that I was a nurse at 12:27
11 various grades working at MAH from...."
12
13 And the witness gives a date in the 1970s:
14
15 "...until 2016. I held both Band 5 and Band 7 12:27
16 positions during this time as well as working as a
17 Nursing Assistant, student nurse and Staff Nurse.
18 The relevant time period that I can speak about is from
19 the 1970s until 2016.
20 12:28
21 For a brief period my relative, whilst training as a
22 student nurse at Queen's University Belfast, did two or
23 three bank shifts per week in other wards at MAH. They
24 would, however, complete shifts on the ward when I was
25 a ward sister at MAH but that was not a regular 12:28
26 occurrence.
27
28 I had always been interested in nursing, particularly
29 nursing those with mental health issues and learning

1 disabilities. I had heard about MAH during my
2 pre-nursing course at college.
3
4 In the 1970s I applied to MAH to become a student
5 nurse." 12:28
6
7 The witness then describes being offered a role as a
8 Nursing Assistant as they were too young to be a
9 student nurse.
10 12:28
11 I am going to pick up then a quarter way through the
12 paragraph, the witness continues:
13
14 "During my time as a Nursing Assistant, I spent time on
15 Foy Beg Ward, which was an adult female ward at MAH. 12:29
16 All of the patients on this ward had a learning
17 disability. In my role as Nursing Assistant I assisted
18 the qualified nursing staff on all aspects of care for
19 the patients such as washing, feeding, dressing and
20 assisting with the activities during the day. In the 12:29
21 morning, at the beginning of my shift, there would be a
22 handover with the nursing staff who had worked the
23 previous night shift. I and the other nursing staff
24 would receive patient reports and be informed of
25 whether anything had arose during the previous night 12:29
26 shift which the day staff should be notified about.
27 The nurse in charge then would have allocated the staff
28 duties, including assisting patients with their
29 personal care, such as bathing, getting dressed, making

1 their beds, assisting with feeding and escorting them
2 to day care or appointments they may have. Nursing
3 assistants would also help with general ward chores
4 such as organising patient laundry. There was a day
5 care facility on the hospital grounds where Foybeg 12:30
6 patients had a placement and I would assist with
7 escorting them there and back to the ward. A lady..."
8
9 Who the witness names: "...ran the day care room which
10 Foybeg patients attended by herself but would have been 12:30
11 assisted by the Nursing Assistants from Foybeg Ward."
12
13 The witness then describes starting a student nurse
14 training school at Muckamore the following year which
15 included multiple ward placements, placements in other 12:30
16 hospitals, learning about psychiatric illnesses and how
17 to manage challenging behaviour.
18
19 I'm going to then pick up over the page half way down
20 paragraph six. The witness continues: 12:30
21
22 "I always recall the routine on the wards as being
23 quite institutionalised at the beginning, but that is
24 how things were done back then before personal care
25 plans for patients were brought in. Every patient was 12:31
26 cared for the same. However, those with different
27 needs received individualised care to meet those needs.
28 Care was not as individualised back then. However,
29 those with specific or more complex needs received care

1 to meet these needs.

2

3 I always found that there was a good atmosphere on the
4 wards for both staff and patients. Aside from being
5 overcrowded, for example on Finglass Ward, there were 12:31
6 two dormitories lined with beds. Most of the patients
7 were physically disabled and required wheelchairs which
8 restricted space even more. MAH was well maintained,
9 particularly the lovely grounds, and there were great
10 facilities for the patients to use, including a 12:31
11 swimming pool on site which I thought was fantastic.
12 Patients were also taken on day trips in small groups
13 into Antrim for shopping. The patients would have had
14 lunch or dinner at the Deerpark Hotel, Antrim as well.
15 However, society was not as accepting back then as it 12:32
16 is now. People, passers-by were cruel to patients and
17 made derogatory comments when we had them out in
18 public.

19

20 Upon qualification as an enrolled nurse, the first ward 12:32
21 I worked on was Rathmore which was a mixed gender ward
22 with patients over the age of 18. Patients were always
23 given the choice of what they would like to do, such as
24 relax, knit, listen to music or spend time in the
25 communal dayroom which was supervised by two nursing 12:32
26 staff at all times. I recall there was an on-site
27 hairdresser too. In the evening time, I assisted the
28 patients at dinner time who required assistance and
29 supervised the dining area with other members of staff.

1 Some patients required more assistance at meal times
2 than others depending on their needs and this
3 assistance may have included cutting up their food or
4 feeding them. Afterwards the patients would play games
5 or watch television in the day room. There were also 12:33
6 dances organised in the large recreation room which the
7 patients really enjoyed. During the summer patients
8 had the opportunity to go on trips. One trip I recall
9 was Bangor, Co. Down where we stayed in a holiday guest
10 house. 12:33
11
12 When I went to MAH I was a little taken aback at the
13 number of patients in the hospital with learning
14 disabilities, especially coming from a rural area
15 myself. I recall being slightly shocked at the number 12:33
16 of patients on the wards, particularly after I was
17 informed that some of them had been there since they
18 were young children. Once I was used to the wards and
19 my surroundings, I realised it was a great community
20 full of patients who would regularly be singing, 12:34
21 dancing and using sign language. The care and routine
22 provided to patients was great. I spent six months on
23 Foybeg as a Nursing Assistant before moving to Fennor
24 ward, which was also a female adult ward, although the
25 patients there were more independent and required less 12:34
26 assistance than patients I had previously cared for.
27 I carried out the same duties on that ward as I did on
28 the previous one and enjoyed my time there.
29

1 There were, of course, differences between the various
2 wards at MAH and each came with their own challenges.
3 Depending on the patients you were looking after,
4 whether that was male or female, younger or older and
5 the severity of their learning disability and/or mental 12:34
6 capability, some were very aggressive. I did encounter
7 violent patients throughout my time at MAH who would
8 have hit out at other patients as well as members of
9 staff. Overall, the approach taken to the general
10 treatment of patients depended on the ward that you 12:35
11 were working on.
12
13 The make-up of each ward tended to be very different
14 and the level of the patient's competency and
15 capabilities dictated the level of care they required. 12:35
16 Some patients would have had very restricted mobility
17 and would require more assistance with their personal
18 hygiene care than those who were more able to do so
19 themselves. There were times when staff had to
20 physically intervene if a patient was becoming 12:35
21 physically aggressive toward another patient or member
22 of staff. Staff members would have had to link arms
23 with the patient and redirect them from the situation
24 that was causing them to become aggressive to a quieter
25 area of the ward, which at times would have been to the 12:35
26 seclusion room. This would have depended on the ward
27 and whether or not it had a seclusion room."
28
29 The witness then describes working as an enrolled nurse

on Rathmore Ward in 1981. And the witness then continues at paragraph 12:

"In 1988 I went back to train as a registered nurse, equivalent to a Band 5 today, which was all done at MAH, both practical and theory."

The witness then describes how long they spent on various wards, including Conicar, Movilla, a placement at Hollybank Residential Unit, at the MAH day care and then the Ennis ward in 1989.

And the witness continues overleaf:

"There was certainly a different approach to the general treatment of patients depending on both the ward and the Ward Managers. I would have always followed the Ward Manager's guidance in regards to patient's treatment, although the Ward Manager would take suggestions on board if a member of staff raised something with them that they thought could be done better or in a more efficient way, and that was the same across all of the wards I worked on during my time at MAH. The type of treatment a patient received depended on their own individual needs and capabilities. Patients with lower abilities needed much more assistance with personal care, such as bathing and feeding. Patients with higher abilities were more independent and, depending on the ward, would

1 have had their own rooms with their own Walkman
2 cassette players and TVs. They could also choose their
3 own activities.
4
5 In 1989, I qualified as a Staff Nurse and my first 12:37
6 placement was on Fintona North Ward, which was a
7 semi-secure all female ward with locked doors. This
8 ward had patients with learning disabilities and some
9 with mental health issues."
10 12:37
11 The witness then continues to describe, in 1991,
12 spending time on Cushendun Ward and then Clonsee
13 Children's Ward.
14
15 Picking up on the next paragraph: 12:38
16
17 "In February 1994, I moved to Rathmore Ward with some
18 patients from Clonsee Ward who did not have a community
19 placement upon the ward's closure."
20 12:38
21 The witness then describes working on Rathmullan Ward
22 in 1995 and staff being clear about their duties and
23 patient allocation due to the use of allocation sheets.
24
25 The witness then continues: 12:38
26
27 "In 1999, I cannot recall which month, I moved to
28 Fintona North Ward and worked as a Band 5 Staff Nurse
29 until 2004. I recall H823 was the Ward Manager at the

1 time I moved to Fintona North but she left towards the
2 end of 1999 or early 2000 and H829 took over her
3 position. H829 was very experienced and had been in
4 MAH a long time. He was the Ward Manager until around
5 2003. 12:39
6
7 Fintona North was a semi secure female ward with locked
8 doors. Initially, I found this ward very difficult to
9 work on due to the typically aggressive nature of the
10 patients. Some would have been admitted through the 12:39
11 courts following criminal proceedings, basically there
12 under a Hospital Order by the Department of justice.
13 Oftentimes patients would have absconded, which was
14 very challenging. I was the named nurse for one
15 patient - whose name I cannot recall - who had a high 12:39
16 level of functioning with good abilities but would have
17 regularly attempted to abscond. I supported this
18 patient and would have escorted her to court
19 appearances as she required full-time supervision off
20 the ward given her status as a Department of Justice 12:39
21 patient. I cannot recall the offence she had committed
22 that resulted in her attendance being required at court
23 on a number of occasions. This ward took admissions
24 directly from the community. Due to the aggressive
25 nature of the patients who had learning difficulties 12:40
26 and mental health issues, they could no longer be
27 managed at home or within any other facility which is
28 why they required admission to MAH.
29

1 During my time on this ward I was always clear on what
2 my duties were. Staff were briefed every morning by
3 the night staff during handover and there was an
4 allocation sheet prepared every day with different
5 tasks allocated to each staff member. Some patients 12:40
6 required one-to-one care or two-to-one care depending
7 on their behaviours. MAH's patient level of
8 supervision policies dictated that staff should rotate
9 every two hours. However, due to regular staff
10 shortages this was not always possible. The impact of 12:40
11 this on patients was therapeutic. Patients would have
12 also preferred certain staff over others so they were
13 allocated those staff if possible as it helped with the
14 patient's mood due to the therapeutic relationship they
15 had with that staff member. 12:41
16
17 I successfully applied for a temporary role as a Band 7
18 ward sister in 2004. This role was on a children's
19 ward called Conicar Ward and most of the patients there
20 were part time. It was a place for respite for 12:41
21 children and they would have spent a mix of weekends or
22 two or three days a week at MAH. I do recall there
23 were some patients on the ward who were over 18 years
24 old that should not have been there and they
25 transferred to adult wards following my uptake of the 12:41
26 ward sister post."
27
28 The witness then describes working as a ward sister on
29 Greenan Ward in 2005 and moving to Fintona Ward as a

1 Band 7 ward sister:
2
3 "Following the closure of Fintona North Ward in
4 February 2009, I opened and moved to Killead Ward which
5 was a newly built amalgamation ward consisting of both 12:42
6 male and female patients from other wards in MAH.
7 However, there were too many issues arising between the
8 patients particularly in relation to boundaries and the
9 patient's reduced capacity to understand and respect
10 those which resulted in the ward being made male only. 12:42
11 Male patients, particularly if they had impaired
12 understanding, would have behaved inappropriately
13 toward female patients such as not recognising ward
14 boundaries. But no such incidents would have caused
15 harm to female patients or would have required serious 12:42
16 adverse reporting. Any inappropriate behaviour would
17 have been reported via Trust incident reporting
18 procedures. When the ward became all male patients it
19 was great for those patients as they had their own en
20 suite bedrooms, a games room to use, a kitchen for 12:43
21 basic cooking and a number of small rooms for relaxing.
22 I enjoyed my time working on this ward.
23
24 Prior to leaving, my job was becoming more challenging
25 and stressful due to the lack of staff. H77, who was 12:43
26 my Senior Nurse Manager at the time, was aware of the
27 staff shortages throughout MAH and did his best to
28 support me, whether that was by trying to allocate
29 additional staff or listening to staff members vent

1 their frustrations. Every ward at MAH was operating
2 under a staffing deficit and this problem was ongoing
3 for years. I do appreciate that senior management did
4 the best they could with the limited resources made
5 available to them, but the struggle to get new staff 12:44
6 in, together with the struggle of retaining existing
7 staff, put the safety of both patients and staff at
8 risk. There were a lot of staff in the hospital
9 employed on temporary contracts due to the prospects of
10 wards closing and patients being resettled to community 12:44
11 placements.
12
13 Throughout my time at MAH working on various wards
14 I always felt supported by senior management. However,
15 that changed around 2012 but I cannot recall the date 12:44
16 exactly. A new Service Manager, H507, took over from
17 H359 and her management style was very different. H359
18 knew all patients and everyone across every discipline
19 of staff in the hospital. She was always available
20 which made staff feel supported. This did not appear 12:44
21 to be the case with H507 who did not seem to show the
22 same interest in patients or staff at MAH and would not
23 have known all staff on a name basis. When H507 was in
24 charge it felt as if there was a pressure to move
25 patients out into the community and close wards. In 12:45
26 certain cases, placements did not holistically meet
27 patients' needs causing the placement to break down and
28 resulted in the patient being returned to MAH. There
29 appeared to be a deterioration in relationships among

1 H507 and senior nurse management. H507 did not appear
2 to show the same interest in the care of the patients
3 as H359 did. During this time it was as if MAH had
4 been forgotten about by the Belfast Health and Social
5 Care Trust and was at the bottom of the list when it 12:45
6 came to funding for additional staff. This time period
7 was the only time I did not feel supported in my role
8 at MAH since my initial role as a Nursing Assistant in
9 the 1970s.
10 12:46
11 Prior to H507 taking up her role as Service Manager,
12 I always felt I could speak to management about
13 anything at MAH. Issues such as wards closing and
14 patients who did not have community placements were
15 then moved into wards where there were availability 12:46
16 rather than into a ward that suited their complex
17 needs. I would have only raised concerns about
18 staffing levels with senior management or relayed the
19 frustration of staff which they expressed to me. Staff
20 at times would request a transfer to another ward if 12:46
21 they found working on Killead became too difficult due
22 to staffing shortages and the challenging environment.
23 It was common to see issues arise between patients such
24 as becoming physical with one another and physical
25 attacks on staff from patients in this environment." 12:47
26
27 CHAIRPERSON: Would that be a convenient point?
28 MS. BERGIN: Certainly.
29 CHAIRPERSON: You're about -- you're exactly a third of

1 the way through?
2 MS. BERGIN: Yes, certainly.
3 CHAIRPERSON: I'm just looking, there is no obvious
4 break in the themes, I don't think. All right, we'll
5 take a break there and we'll resume at 2 o'clock. 12:47
6 Thank you everybody.
7
8 THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:
9
10 CHAIRPERSON: Thank you. Page 10? 13:58
11 MS. BERGIN: Yes, good afternoon, Panel and Chair,
12 paragraph 24, at the top of page 10.
13 CHAIRPERSON: Just give me a second. Yes, thank you.
14 MS. BERGIN: Thank you, Chair:
15 13:59
16 "Throughout my time at MAH I was always clear on the
17 purpose for each patient's admission. In my earlier
18 years of training and later while working as a Band 5,
19 information on a patient would have been received in
20 advance of the patient's arrival to the hospital and 13:59
21 would have most often come from the patient's social
22 worker. If a patient was brought for admission by a
23 family member, then that family member would have given
24 staff additional information about the patient at that
25 stage, including anything they felt relevant for staff 13:59
26 to know to ensure the patient received the best care
27 and meet their needs.
28 A patient's notes was the main source of information on
29 patient's history, including how they were currently

1 cared for and why a patient was being admitted to MAH.
2 This would have been contributed to by a number of
3 professionals who had cared for that patient throughout
4 their life, including community learning disability
5 teams, psychologists, consultants and dieticians. 14:00
6
7 Families' involvement with patients on the wards varied
8 throughout my time at MAH, some were very involved and
9 would visit regularly, providing staff with insight
10 into the patients and contributing toward their care 14:00
11 plan, but other patient's families would never or
12 rarely visit and it was not uncommon to see a patient
13 go many years without a visitor. I recall one mother,
14 who did not like that her daughter was being medicated
15 to deal with her epilepsy and behavioural issues, but 14:00
16 it was because of these conditions that she required
17 the medication. That patient's name was P117.
18 However, her mother did not make any formal complaints
19 regarding her medication, but she would have met the
20 consultant to discuss the medications regularly. 14:00
21
22 I do recall instances of family members raising
23 complaints about the treatment of their family members
24 and other issues raised such as misplaced personal
25 items on the ward. These complaints would have been 14:01
26 dealt with and recorded at ward level. However, family
27 members were also informed of the Belfast Trust
28 complaints policy procedures if they were not satisfied
29 with how this was dealt with.

1
2 Staff members would not always be immediately aware of
3 each patient's skills or capabilities unless they had
4 nursed them previously, either in another ward or
5 during a previous admission. If the admission was 14:01
6 planned, there would be a meeting with the patient's
7 community care team who would provide a high level of
8 detail in regards to patient information, including
9 their abilities, but if the admission was of an urgent
10 nature or out-of-hours, you may not be provided with 14:01
11 that information at the beginning. If this information
12 was not made available at admission stage, myself or
13 another member of staff would follow up with a phone
14 call to the patient's family and social worker. This
15 was also the same process with regard to any 14:02
16 challenging behaviours a patient may have. Things did
17 improve in later years at MAH as there was more
18 involvement with each patient's community and
19 behavioural teams.
20 14:02
21 During my time as a Nursing Assistant, I would not have
22 had much involvement in the role of assessing the
23 patient following admission. When I took up my role as
24 a Staff Nurse, I would have had more input into a
25 patient's overall assessment. This was typically done 14:02
26 by relaying information back to the multidisciplinary
27 team.
28 When I was a ward sister on Fintona North Ward and
29 later Killead Ward, treatment plans consisted of a

1 variety of treatments depending on the particular
2 patient. There were weekly multidisciplinary team
3 meetings which were attended by the patient's named
4 nurse or Ward Manager, day care worker, social worker,
5 psychiatrist and, if required, a dietician who would 14:03
6 have made observations and contributed toward the
7 patient's care plan. During these MDT meetings,
8 treatment plans would have been reviewed and there
9 would have been discussion regarding the effectiveness
10 of the treatment plans in place and the medication 14:03
11 prescribed to patients. Staff would have documented
12 daily how that particular care plan was working for the
13 patient and any adverse impacts of the care plan. This
14 would have then been discussed at the following MDTM.
15 14:03
16 A patient's care plan would have consisted of detailed
17 objectives as to how the patient's identified needs
18 would be met. Consultants would make decisions on
19 medication and they would have received a lot of
20 information on the patient from the nursing staff, GPs 14:03
21 and the patient's community notes. If a patient
22 appeared to be overmedicated to the point the
23 medication was having an adverse effect on them, such
24 as appearing drowsy, this would be reported back to the
25 medical team who would have raised the issue 14:04
26 immediately. Medication to be used as required or pro
27 re nata, PRN, would be administered to patients outside
28 of regularly prescribed medications for various reasons
29 depending on the medication. This may be to reduce a

1 heightened state of distress or anxiety, provide pain
2 relief and oftentimes a patient would have requested
3 their PRN themselves if they felt they needed it. All
4 administration of medication was recorded in the
5 nursing notes and medication Kardex, which is the main 14:04
6 tool used to direct administration of medicines in a
7 hospital setting. Any changes to medications or newly
8 prescribed medications would have also been noted in
9 the care plan, medical notes and the medication Kardex.
10 14:05
11 All patients at MAH had a care plan that was
12 individualised and tailored to their specific needs.
13 Care plans would have been made up with various
14 treatments and would include activities of daily
15 living. The care plans would have also included 14:05
16 patient's physical, psychological, emotional, social
17 care needs, their level of communication, activities to
18 suit their abilities and how to meet their physical
19 health and nutritional needs. Care plans would be
20 devised following a patient's initial assessment and 14:05
21 when needs were identified from this, these would have
22 been discussed at regular MDTMs. Medication
23 prescription would have been included in a patient's
24 care plan and quite a lot of patients would have been
25 diagnosed with epilepsy, a mental illness or diabetes. 14:05
26 For example, various anti-psychotic medications were
27 regularly used for those who were experiencing mental
28 illness such as schizophrenia or bipolar. As well as
29 care plans being discussed at MDTMs, they were also

1 reviewed on a weekly basis by staff on the wards who
2 would note their observations and in particular whether
3 or not the care plan was beneficial for that patient or
4 if they thought changes should be made.
5 14:06
6 All of this information would have been recorded on the
7 patient's nursing notes as well. I always felt
8 comfortable speaking to other nurses as well as medical
9 staff if I saw something that I did not think was
10 working well for a particular patient. The weekly 14:06
11 MDTMs were usually held on a Friday. Some patients
12 would also have had positive behavioural support plans,
13 PBSPs, that would have been prepared by the behavioural
14 support team. These behavioural support nurses would
15 have attended the wards regularly to observe patients, 14:06
16 to assess the effectiveness of the PBSPs in place.
17
18 I recall H177 was the linked person during my time on
19 both Fintona North Ward and Killead Ward and she would
20 have done a lot with patients. H177 would have met 14:07
21 with Ward Managers to give her input into patient's
22 care, particularly the PBSPs, and she would also have
23 chatted with patients who had a relatively high level
24 of communication and taken their input on board when
25 reviewing the PBSPs. H177 would also have delivered 14:07
26 individual and group cognitive behavioural therapy
27 alongside H210 and H209 who were also part of the
28 behavioural support team. CBT is an alternative
29 therapy used to help manage a patient's problems by

1 changing the way they think and behave. It was a
2 common part of care plans for higher functioning
3 patients suffering from anxiety and depression. PBSPs
4 would have been agreed at the patient's MDTM.
5 14:08
6 I was always made aware of any risks posed by patients,
7 either from their family during admission, their
8 community support team or directly from patients
9 themselves. Following a patient's admission, there
10 would be an MDTM to discuss their care plan and assess 14:08
11 any risks they posed. For example, some patients may
12 have had violent tendencies, showed higher levels of
13 aggression or, depending on the admission and ward, may
14 have had a history of sexual assault. It would have
15 been the duty of staff members to monitor any risks 14:08
16 that the patient posed and to ensure care plans were
17 effective to mitigate those risks. This was also the
18 case with patient vulnerabilities and would have been
19 the same process for making staff aware of those as
20 well as assessment and monitoring afterward. Any 14:08
21 incidents would have been recorded in an incident book
22 on the ward and in the Datix on-line system in later
23 years, which is a risk management information system,
24 and noted on the patient's notes. Patient's next of
25 kin were updated following any incidents. Senior nurse 14:09
26 management would have been made aware of any incidents
27 and would have then progressed that further up the line
28 with the Trust, if required.
29

1 Meal times at MAH were supervised in differing ways
2 depending on the ward. All staff would have been on
3 the floor serving meals to the patients who would have
4 ordered from the daily menu the day before, so they had
5 individualised choice regarding their meals. If 14:09
6 patients were able to do so, they could go up to the
7 hatch in the dining area and collect their own food.
8 All nursing and nursing assistant staff would have
9 provided assistance to those that required help with
10 cutting up their food and assistance with feeding. 14:10
11
12 Throughout my time at MAH I was always very clear as to
13 what restrictive practices could be used and when it
14 was appropriate to use them. When I worked on Fintona
15 North Ward, it was rather difficult because it was a 14:10
16 locked ward, so it was a restrictive environment right
17 from the start. Training was provided by MAH in
18 management of actual or potential aggression, MAPA.
19 This was as a means of last resort when other
20 de-escalation techniques would not work to de-escalate 14:10
21 a patient. All staff were provided with full training
22 in MAPA techniques and yearly refreshers were
23 mandatory.
24
25 The initial training took five days and the refresher 14:10
26 training took place over two days. MAPA techniques
27 could not be used by any staff member that was not
28 fully trained. There was a seclusion room in Fintona
29 North and staff were very clear that it was to be used

1 as a last resort and must be prescribed by the nurse in
2 charge or next Senior Staff Nurse if the nurse in
3 charge was not on the ward at that time. Nursing staff
4 were always taught that verbal de-escalation was to be
5 used first and restraint holds as a last resort. If a 14:11
6 patient became physically violent, either towards staff
7 or another patient, or they were in a heightened state
8 of distress, you would always use the least physically
9 restrictive method. However, the use of restraint and
10 restrictive practices would have been more of a regular 14:11
11 occurrence on Fintona North due to the higher levels of
12 aggression, self-harm and threat to others that many of
13 the patients displayed.
14
15 If a patient was showing signs of distress, the first 14:11
16 thing to do would be to speak to them if they were able
17 to verbally communicate to try and understand what was
18 wrong. Sometimes a patient would be distressed if a
19 family visit was cancelled at short notice by the
20 family and it would have been the responsibility of 14:12
21 staff to redirect them to something more positive. It
22 would have also been common for patients to have been
23 prescribed PRN medications as part of their care plan,
24 and, as I mentioned previously, they would have
25 requested this themselves if they were feeling in pain, 14:12
26 anxious or distressed. If PRN medication did not help
27 alleviate the patient's distress and they remained
28 highly agitated or distressed, then a restrictive
29 practice may have been required. This might have been

1 a restraint hold to reduce harm to themselves or others
2 whilst in that heightened state, or, if that was not
3 effective, possible seclusion may have been required.
4
5 Seclusion policies and procedures were in place for 14:12
6 this at MAH and they were strictly adhered to by all
7 staff. Seclusion was authorised by the nurse in charge
8 or most Senior Staff Nurse following the nurse in
9 charge if they were not present at that time. The use
10 of restrictive practices was well documented and 14:13
11 recorded in the patient's notes and would have been
12 discussed and reviewed during MDTMs if the use was
13 becoming more regular.
14
15 Decisions relating to restraint and seclusion were 14:13
16 always taken by the nurse in charge of the ward at the
17 time or the most senior staff member around if the
18 nurse in charge was unavailable. They would have made
19 the decision on what was necessary depending on the
20 situation. Seclusion was not always used but patients 14:13
21 may have been brought to a quieter part of the ward to
22 allow them to calm down. As I have mentioned, staff
23 were trained to use all other methods of de-escalation
24 before taking a patient to seclusion. Some patients,
25 who may have had a history of self-harming, such as 14:13
26 cutting themselves or swallowing batteries, would be
27 supervised much more closely than those who did not.
28 For example, if a patient had a history of swallowing
29 batteries, then these would have been removed from

1 anything in their room such as remotes or CD players.
2 Similarly, if they had a history of self-harm, then
3 staff would have removed any sharp objects from their
4 room. If a patient was ever found to be self-harming
5 then staff were trained to remove from them whatever 14:14
6 they were using to harm themselves and place in a
7 secure store away from the patient's access until
8 self-harming behaviours had reduced or it was deemed
9 safe for them to have these again.
10 14:14
11 I recall two patients, P193 and P194, who were patients
12 on Fintona North and Killead and both with histories of
13 self-harm, so they were supervised more closely than
14 patients who did not have that history and would have
15 received one-to-one care at times depending on their 14:14
16 mental state. I also recall one patient, P195, who
17 would request that she be placed in seclusion Fintona
18 North if she began to feel anxious or overwhelmed.
19 P195 had an abusive childhood and being placed in
20 seclusion was where she felt most safe while on the 14:15
21 ward. She had her own room on Fintona North that had a
22 lock on the inside of the door which she could lock
23 herself to feel extra safe, but staff were able to open
24 this from the other side with a key in the event that
25 she needed assistance. Before that, she would have 14:15
26 always wanted to be in the seclusion room or have staff
27 lock her bedroom door. Therefore, this was person
28 centered to P195's care and good practice.
29

1 The use of CCTV was not introduced on the wards during
2 my time at MAH. I recall it being discussed very
3 generally amongst the more senior members of staff, but
4 to my knowledge there were no cameras in operation
5 before I left. 14:16
6
7 I was always made aware of when patients were being
8 discharged because of the regular MDTMs. I would have
9 been made aware of what placements were available and
10 the wider team would have contributed to the decision 14:16
11 on whether or not they felt that the placement was the
12 right fit for a particular patient or if they thought
13 the patients were even ready for resettlement. There
14 were also separate community placement meetings with
15 staff from the proposed resettlement unit to see how 14:16
16 they built a rapport with patients. This included both
17 in-reach and out-reach to allow the patients the
18 opportunity to see their new placement and whether or
19 not they would interact with their new staff.
20 I contributed to discussions by talking about my 14:16
21 observations of patients and whether or not I thought
22 they were ready to be resettled into the community.
23 There was no training as such for this process. It was
24 about working with the patients, the staff in the
25 community teams and deciding whether or not I thought 14:17
26 it was suitable for them at that stage of their care.
27 I never requested any specific training as I was
28 comfortable learning from others and felt competent
29 enough in my role to be able to contribute to

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1 discussions at meetings. Patients would have had
2 trials in their placements and MAH staff would have
3 gone with them to support the transition to help
4 prevent readmissions. Family would have also
5 contributed to discussions and let the MAH staff know 14:17
6 if their family member did not seem happy following
7 resettlement or if there was more support required to
8 help them settle in.
9
10 I started my first temporary Band 7 post as a Ward 14:17
11 Sister in 2004 in Conicar Ward and worked there until
12 2005. There were around 10 children on the ward and
13 they ranged in age from five years old up to 18.
14 I found this ward less challenging to Fintona North
15 Ward as the children had much lower levels of 14:18
16 aggression than patients in Fintona North. Most
17 children on the ward were shared care with their
18 families. The children were usually in Conicar to give
19 their families respite and shared care as their
20 behaviours could be quite challenging. I cannot recall 14:18
21 how many staff would have been on the ward at the time
22 but some children did need one-to-one supervision and
23 the team of staff was large enough to facilitate this.
24 All of the children would have left the ward at some
25 stage throughout the day, usually to a classroom on 14:18
26 site for short periods of time.
27
28 Conicar was an old ward and the children slept upstairs
29 in shared areas. Most were able to wake up themselves

1 but staff assisted them with personal hygiene and
2 dressing before attending the dining room for
3 breakfast. Afterwards, the children would go either to
4 the behavioural unit on site, which was the behaviour
5 nurse therapy unit, or to their school off site 14:19
6 escorted by staff, depending on each child's timetable.
7 Any children who would have remained on the ward made
8 use of the soft play area, went on walks with staff,
9 did arts and crafts, cooked in the kitchen or went for
10 a swim in the on-site pool. The children loved the 14:19
11 range of activities offered at MAH. The children would
12 have had their lunch around 11:45 am. All of the
13 children would have had a care plan that was reviewed
14 during the MDTMs.
15 14:19
16 H588 and H832, both staff members on the behavioural
17 support team, would have devised the care plans for the
18 children which were reviewed weekly. There were also
19 meetings with their teachers and headmasters if the
20 child had been suspended or expelled from school due to 14:20
21 their behaviour. These meetings were to help
22 re-integrate the child back into school. Any incidents
23 that took place on the ward where children might have
24 been aggressive with one another were logged the same
25 way as any incident at MAH in the incident book and in 14:20
26 their patient notes. The children's parents would also
27 have been notified. However, there were not instances
28 during my time at MAH where a parent lodged a complaint
29 about the treatment of their child. Incidents on

1 Conicar were much easier to manage and I did not have
2 to use physical restraint on any child during my time
3 there, or even seclusion. There were also a lot of LAC
4 reviews, Looking After Children, during my time on this
5 ward, and those would have had up to ten or 12 people 14:21
6 involved, such as the child's social worker,
7 behavioural psychologist and teachers, as well as the
8 hospital consultant and any other medical staff as
9 necessary. I do not recall being given specific
10 training to deal with children. However, I was guided 14:21
11 by other nursing staff as well as MAH policies and
12 procedures. I took guidance from the child's care plan
13 and their medical file, including the social workers'
14 reports and psychology reports, so I had access to all
15 the information I needed to provide the children with 14:21
16 the care they needed.
17
18 I do not recall any serious incidents occurring during
19 my time on Conicar Ward either between staff and
20 patients or patients and patients. There were also no 14:21
21 complaints made to me during this time regarding
22 patient care or safeguarding.
23
24 I moved to Greenan Ward in 2005 as a ward sister. This
25 was a mixed care of the elderly ward. Some would have 14:22
26 been diagnosed with autism and others may have had
27 diabetes or asthma and been wheelchair bound or require
28 a walking aid. The patients would have required
29 assistance with feeding. Getting washed and dressed

1 was supported by a team of Staff Nurses and nursing
2 assistants. There was also no allocated secretarial
3 support either and a lot of the administrative duties
4 had to be done by nurses themselves. I recall there
5 was a general secretarial pool for MAH. However, as 14:22
6 they were carrying out administrative duties for the
7 entire hospital, it was quicker for nursing staff to do
8 it themselves.
9
10 During my time on Greenan Ward I never had any issues 14:22
11 that were of concern or that required reporting. The
12 patients were not challenging and would have normally
13 only required assistance with eating, walking or
14 personal care. There was a very high standard of care
15 on this ward as staff were very experienced and well 14:23
16 trained. It was rare that you would have had a direct
17 external admission onto this ward but you would have
18 seen some internal transfers if patients had to come
19 from another ward to convalesce."
20 14:23
21 **The witness then describes the direct admission of one**
22 **elderly patient. The witness continues:**
23
24 "The elderly patient's care plans were mostly physical
25 as opposed to behavioural. The only restrictive 14:23
26 practices used would have been wheelchair restraints to
27 ensure their safety. Their physio had a great deal of
28 input in their care plans which was reviewed on an
29 ongoing basis every month. The registrar, Doctor H613,

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1 would have reviewed patient's medication on an ongoing
2 basis. During the week, Monday to Friday, Doctor H613
3 would have called to the ward every morning to review
4 patients' medications. The process of resettlement of
5 the elderly patients was very slow and I can only 14:24
6 recall two being identified during my time on Greenan
7 Ward.
8
9 I then moved back to Fintona North in 2005 as ward
10 sister until 2009. A lot of the same staff who I had 14:24
11 worked with previously on this ward were still there as
12 well as most of the same patients. This made it much
13 easier to go back to and everything was much the same,
14 only I now had more responsibility due to my higher
15 position. As I have mentioned before, the patients on 14:24
16 this ward were much more challenging than the others
17 that I had cared for while working at MAH. However, on
18 this occasion I felt experienced enough to manage this.
19 I knew from my own experience as a Staff Nurse what
20 challenges the staff were faced with. We had ward 14:25
21 meetings every few months, but not all staff could
22 attend if there was not enough cover on the ward, so
23 minutes of the meetings would be shared with all staff
24 afterwards and they then had the opportunity to raise
25 any issues they had, such as staffing shortage or 14:25
26 identifying more activities for the patients or
27 recommendations they wanted to make toward the care of
28 patients or the ward generally.
29

1 My responsibility during this time was to ensure the
2 highest standard of care was provided to each patient
3 and that MAH policy and best practices were followed at
4 all times by staff. The environment was not ideal due
5 to staff shortages, the layout of the building and the 14:25
6 high risk posed by certain patients but communications
7 amongst staff was always excellent. Meal times on
8 Fintona North during this period were staggered,
9 usually to accommodate patients with diagnosed autism
10 so as to accommodate any sensory issues they were 14:26
11 likely to encounter in a busy dining room with loud
12 noises. I remember one patient, whose name I do not
13 recall, chose to be seated by herself as she did not
14 like other people being at her table. Nursing
15 assistants were great at reporting back any issues that 14:26
16 patients may have been having, or if they were
17 generally feeling unwell. Patients would have confided
18 in certain staff members that they had a better rapport
19 with and provided them with information they would not
20 have felt comfortable sharing with others. This was 14:26
21 more often than not related to something that happened
22 to them in the past. I always felt the nursing
23 assistants had a big responsibility working with
24 challenging patients.
25 14:27
26 During my time in Fintona North, I cannot recall any
27 major issues occurring with patients or between
28 patients and staff. However, there were regular
29 occurrences of aggression from patients towards staff.

1 At times patients would have been distressed or
2 frustrated which affected their behaviour. Staff knew
3 to be more vigilant with certain patients who were
4 prone to self-harm or more aggressive outbursts, but,
5 more importantly, how best to de-escalate those 14:27
6 patients without using any restrictive practices or
7 seclusion.
8
9 The ward was always well maintained. As I was in
10 charge, I ensured that all staff completed their yearly 14:27
11 mandatory training in physical intervention, manual
12 handling, safeguarding adults and infection control was
13 required by the Trust. Training records were kept
14 updated and completed by staff. If staff wanted to
15 attend additional training they would speak to me as 14:28
16 the ward sister who would then arrange that, if it was
17 applicable to their practice.
18
19 The Trust did get better at bringing training on site
20 at MAH, however it was usually in Belfast. My role 14:28
21 with discharging or resettling patients in this role
22 was not too different from my previous role and it was
23 the patient's named nurse who would have had more input
24 as they would have attended all the patient's MDTMs and
25 other meetings. In my role I had to be kept informed 14:28
26 as to what was happening with patients and when they
27 were scheduled to be discharged or resettled.
28 I opened and moved into Killead Ward as ward sister in
29 2009 until I left MAH. Initially the ward was made up

1 of 24 male and female patients who would have had
2 learning disabilities alongside other mental health
3 issues, such as schizophrenia, anxiety, depression or
4 bipolar disorder. This environment was more suitable
5 for the patients as it was larger and they all had 14:29
6 their own en suite bedrooms. There were also a lot of
7 small sitting rooms so that patients had plenty of
8 space to use as quiet areas and to watch TV rather than
9 one communal day space TV room. It was pretty noisy
10 back then because there was a lot of glass separating 14:29
11 the rooms as opposed to brick walls.
12
13 Over time, Killead Ward became an all-male ward due to
14 issues arising between male and female patients. One
15 issue in particular would have been when a patient 14:29
16 removed her clothes if she was feeling distressed and
17 would wander into other patients' rooms. This patient
18 required increased levels of supervision to ensure this
19 did not happen on a regular basis and to safeguard her.
20 However, I do not recall any major incidents taking 14:30
21 place either between patients and staff that required
22 senior management to be notified or for the matter to
23 be reported to anyone. There would, however, have been
24 regular incidents of aggression between patients and
25 towards staff by patients. Killead was an open ward 14:30
26 and some patients came from Fintona North so were
27 familiar with fellow patients and some of the staff.
28 However, as it was an open ward, there was an increased
29 risk of patients absconding. Therefore, staff were

1 always vigilant and regular head counts were
2 undertaken.
3
4 My role on this ward as ward sister was much the same
5 as on the last ward with regard to being an active 14:30
6 member within the MDT, managing a team of staff,
7 involvement in resettlement and reporting any issues to
8 senior management. There were ongoing reviews of
9 patients' care plans, assessments to determine how the
10 patients were settling into Killead, how their needs 14:31
11 were being met, if other supports needed to be
12 implemented to meet their needs and if other placements
13 were suitable in the community to meet their needs.
14 I always felt there was a great atmosphere on the ward
15 for both staff and patients but particularly staff as 14:31
16 the old ward facilities they previously worked in did
17 not meet patients' needs, so it was nice that both they
18 and the patients had a brand new ward with modern
19 facilities that were more private. It was great that
20 patients now had their own rooms as this gave them a 14:31
21 sense of independence and they would have taken great
22 pride in them making sure they were tidy and set up
23 just how they wanted. Having their own room meant
24 there was always a comfortable and personal area where
25 they could go if they were feeling stressed or over 14:32
26 stimulated in the ward. A patient's environment has a
27 big impact on their care and well-being and when the
28 environment is more suited to their needs they are more
29 relaxed."

1
2 The witness then describes patients coming to Killead
3 as mainly being transfers from Cranfield and other
4 resettlement wards.
5 14:32
6 And picking up over the page, the witness continues:
7
8 "I feel everyone got on really well during my time on
9 Killead, both staff and patients, despite patients
10 transferring in and out regularly. It was a very 14:32
11 welcoming environment particularly to student nurses
12 who we received a lot of. They would have always
13 spoken so highly of Killead and the care they witnessed
14 while training on the ward. I was as involved in the
15 implementation of care plans as before in my previous 14:33
16 roles as ward sister and would have contributed my
17 observations during MDTMs, as would patients' named
18 nurses. This was also the case with treatment plans
19 and staff were always aware of any risks posed by
20 patients, either to themselves or others when they came 14:33
21 onto the ward.
22
23 The general approach to treatment on Killead was
24 individualised and person centred. A lot of patients
25 were more independent and enjoyed attending Moyola, the 14:33
26 day care on site. There was always excellent
27 communication between staff on Killead and the staff at
28 Moyola."
29

1 The witness then describes staff taking patients on
2 trips, including the cinema, to the beach, shopping and
3 patient activities, including football and playing
4 pool.
5 14:34
6 The witness continues:
7
8 "I do recall there was an allegation made during an
9 RQIA assessment, although I cannot recall the date or
10 the specifics of the allegation. A patient, P33, 14:34
11 alleged that a male staff member had pushed him on one
12 occasion. This was reported to me as ward sister and
13 I followed the process of reporting this to H188 who
14 was the vulnerable adult officer at the time. I filled
15 out a VA1 referral form and sent this to H188 for 14:34
16 further investigation as he was the investigating
17 officer for vulnerable adults, as well as the Senior
18 Nurse Manager, consultants and the PSNI were also
19 informed.
20 14:34
21 A PSNI officer would have made visits to the hospital
22 if an incident was reported to the PSNI. I recall H188
23 spoke with the patient for more information on what had
24 happened but the patient said that it had happened a
25 long time ago on a different ward and that he did not 14:35
26 want anything done about this. The staff member could
27 not return to the ward until MAH's internal
28 investigation processed had finished. I cannot recall
29 the ward which the staff member returned to following

1 the conclusion of MAH's internal investigation. It was
2 not uncommon for patients to dislike certain staff and
3 some would have had a history of making allegations
4 that would be investigated by the safeguarding
5 investigating officer and the allegation would be 14:35
6 deemed to be unfounded.
7
8 Another incident I recall while working on Killead Ward
9 during this time involved a staff member called H357
10 being accused of pushing a patient, but, following the 14:36
11 investigation with the safeguarding investigating
12 office, the allegation was unfounded.
13
14 Killead Ward had individual pods on the ward for
15 patients if they needed to be nursed away from others, 14:36
16 particularly if they were prone to showing disruptive
17 or challenging behaviours regularly. I remember there
18 was one patient, P196, a 19 year old, who had his own
19 pod and a two-to-one level of supervision. I felt this
20 was not ideal for P196 at that time but there was no 14:36
21 other option than placing him in a locked ICU which was
22 felt would be too restrictive for him. He still
23 attended day care at Moyola Ward and enjoyed spending
24 time in the coffee shop. But there were a lot of
25 incidents of him attacking other patients and staff 14:37
26 which is why he was nursed in a pod alone for his
27 safety and the safety of others. P196 had transferred
28 into Killead Ward and it was a very challenging time
29 for both him and the staff due to his level of

1 aggression towards staff and other patients. There
2 were no seclusion rooms in Killead Ward but, if a
3 patient became extremely aggressive or in an emergency
4 situation, they may have gone to Cranfield ICU ward for
5 a short time and then came back to Killead Ward. 14:37
6
7 I recall another incident which happened around 2012,
8 although I cannot recall the exact month, where a male
9 Nursing Assistant named H778 had punched a male patient
10 in the head. The patient had become aggressive prior 14:37
11 to this incident and was taken to his bedroom to calm
12 down. After a short period of time the patient had
13 calmed and the staff members had left his bedroom and
14 were walking up the corridor when the patient came out
15 of his room and into the corridor and for some reason, 14:38
16 I do not know why, H778 turned and punched the patient
17 in the head. I did not witness the incident but
18 I heard H779 Staff Nurse, shouting at H778 to stop.
19 I then went over to see what was happening and H778 was
20 walking away from the patient. I spoke with H779 and 14:38
21 asked her what had happened. She told me that I would
22 need to speak with H778, so I took him into the ward
23 office to talk about what happened. He told me that he
24 should not have done what he did but he would not say
25 why. I informed him that I had to report this to H290, 14:39
26 Senior Nurse Manager, and asked him to wait in a
27 meeting room just outside the patient area while
28 I spoke to H290. H290 and I then spoke to H778
29 together and he again said he should not have done what

1 he did. H77, Senior Nurse Manager, came into the ward
2 and spoke to H778 and informed him that he could not
3 work on the ward until an internal investigation was
4 carried out. There was a disciplinary held for H778
5 sometime after the incident. I cannot recall exactly 14:39
6 when I and other staff attended to give evidence about
7 what we saw that day. At this stage H778 changed his
8 story and said he did not hit the patient but the three
9 staff members from Donegore Ward, whose names I do not
10 recall, and H779 from Killead Ward had witnessed the 14:40
11 incident.
12
13 Following the conclusion of the internal investigation,
14 H778 lost his job at MAH. The incident was also
15 reported to the PSNI immediately after it happened and 14:40
16 criminal proceedings were issued against H778. The
17 case was before Antrim court sometime after the
18 internal investigation finished, although I cannot
19 recall the exact date, and H778 remained adamant that
20 he did nothing wrong and had not assaulted the patient. 14:40
21 I cannot recall the exact outcome of the criminal
22 proceedings."
23
24 Chair and Panel, by way of information, the PSNI have
25 notified the Inquiry that this incident was reported to 14:41
26 the PPS and H778 received an adult caution which was
27 administered at court for common assault.
28 CHAIRPERSON: Can you just remind me, and you may not
29 know this straight away, in this jurisdiction does a

1 caution require an admission to the offence? Yep, same
2 in England, thank you.
3 MS. BERGIN: Thank you also to the heads that nodded to
4 confirm my view!
5 CHAIRPERSON: I'll take that as read unless you come 14:41
6 back and correct me.
7 MS. BERGIN: Certainly, I'll check that. Thank you,
8 Chair.
9
10 The witness continues: 14:41
11
12 "In my role as a Band 5 with regard to the allocation
13 of certain aspects of care, this was done by way of
14 allocation sheet which I completed. Each staff member
15 was allocated to a patient or group of patients and 14:41
16 would have certain duties assigned to them, such as
17 escorting patients to appointments at hospital, if they
18 had one, or to Moyola day care. I would have ensured
19 that staff were allocated duties that they were best
20 suited for with their level of experience. More 14:42
21 experienced staff would have been allocated to patients
22 with more complex needs. There was always a registered
23 nurse allocated for outings with patients.
24
25 I would have had oversight of unregistered staff and 14:42
26 would have held informal discussions with them and fed
27 back to the MDTMs what their observations were on
28 certain aspects of care, as well as my own. I spoke
29 with patients who had a higher level of communication

1 to ensure they were happy with staff and the care they
2 were receiving. I also would have ensured general
3 duties were being completed satisfactorily such as the
4 cleaning of the wards.
5 14:42
6 The reassessment of patients was ongoing on a regular
7 basis, but any changes to care plans would have been on
8 a weekly basis following an MDTM. This was the same
9 for the assessment and management of patient's physical
10 health. I would have observed patterns of behaviour 14:43
11 for patients, particularly if they were exhibiting
12 signs of heightened agitation or aggression and ensured
13 it was noted in their patient notes. I would look at
14 what the MDT could do by way of amendment to their care
15 plan to prevent these behaviours from occurring. 14:43
16
17 Decisions regarding PRN medication were always taken by
18 staff trained to the appropriate level of medication
19 administration, Staff Nurses. If I was on the ward,
20 I made an informed decision, if verbal de-escalation 14:43
21 was not working with a particular patient, to
22 administer PRN medication. Some patients, as I have
23 mentioned before, would request PRN medication
24 themselves if they felt they needed it and were able to
25 communicate this verbally. The administration of PRN 14:44
26 medication was always recorded on a patient's notes and
27 medication Kardex. The effectiveness of this would
28 also be documented. If certain PRN medication was
29 being required regularly then this would be discussed

1 with the medical team and medication prescriptions
2 would be reviewed to reduce regular use of certain PRN
3 medications.
4
5 As a named nurse for certain patients, I would have met 14:44
6 with their families to discuss their care plans but
7 some did not want to be involved and I would have
8 documented their decision on this. I would have made
9 them aware of their relative's care plan, what it
10 consisted of and why the decisions were taken regarding 14:44
11 prescribed medications and kept them updated on an
12 ongoing basis.
13
14 Therapeutic interventions used at MAH would have been
15 CBT with input from psychologists and the behavioural 14:45
16 support team. Counselling was also offered to patients
17 and there would have been some that required one-to-one
18 with their consultants once a month. Other therapeutic
19 interventions available for patients would include day
20 care facility, swimming pool, outings with staff, 14:45
21 family visits.
22
23 I would have received clinical supervision in my role
24 as a Band 5 but I cannot recall when this started. It
25 would have taken place every few months and was a sit 14:45
26 down with the Ward Manager to go over my performance
27 and address any concerns regarding patient care I may
28 have had. I did not receive protected time for
29 training (Continued Professional Development).

1 In order to ensure the safe, effective and
2 compassionate care of patients in my role as a ward
3 sister, I would have started the day delegating tasks
4 to the nursing staff, assigning the more competent
5 staff to patients with more complex needs. I supported 14:46
6 staff through any incidents that occurred while on the
7 ward such as patients becoming violent or aggressive
8 towards staff or other patients and ensured that the
9 procedures for reporting were fully adhered to.
10 I valued the staff on my ward and ensured the highest 14:46
11 quality of care through observing them on a daily basis
12 and speaking with them in a formal and informal basis,
13 including their supervision. Staff were aware they
14 could approach me at any time if they needed to discuss
15 any issues they may have had. In order to ensure the 14:46
16 ward was person-centered and tailored to individual
17 needs, I did my best to make sure that staff adhered to
18 the patient's care plans. I would have reviewed staff
19 performance through appraisals and spoke with them to
20 ensure they were clear on what their duties were and 14:47
21 the care they were to provide. I also listened to
22 patients, valued and respected their input into the
23 environment on the ward to ensure they all felt
24 comfortable. Unfortunately there was not enough staff
25 to deliver everything on a patient's care plan. It was 14:47
26 difficult to deliver 100% for patients at times due to
27 inadequate staff numbers. This would have resulted in
28 activities being cancelled, which in turn resulted in
29 patients feeling disappointed or upset by this. There

1 was no full-time psychologist on the wards during my
2 time as a Band 7. There was one, whose name I cannot
3 recall, that was employed by the Trust and to request
4 one to see a patient on the ward required a referral
5 being filled out that could take weeks at a time. 14:48
6 There were occupational therapists at Moyola day care
7 and they would have provided helpful input into a
8 patient's care who was being resettled into the
9 community, as would physiotherapists who were split
10 across the wards. 14:48
11
12 Care plans and nursing records were audited on a
13 regular basis. Peer audits would have taken place
14 every six months or so and the resource nurse, H777,
15 would have carried out spot checks on the wards. There 14:48
16 were also RQIA inspections. The feedback received
17 following any inspection would have varied and could
18 have been anything from insufficient information being
19 provided in patient notes, for example dates missing,
20 or that internal reviews were not being carried out on 14:48
21 a regular enough basis or on time.
22
23 However, we did also receive a lot of great feedback
24 and were regularly praised for the good practice of
25 staff. Any recommendations would have been implemented 14:49
26 as soon as possible such as reviews being scheduled to
27 take place more regularly and this was always shared
28 with staff. The use of PRN medication, restraint and
29 seclusion on the wards was monitored through various

1 reporting methods, including patient notes and their
2 care plans. These were then reviewed and discussed at
3 MDTMs and decisions would have been taken whether the
4 use of PRN medication and/or restrictive practices
5 needed to be increased or decreased. Datix would have 14:49
6 been used by staff to lodge reports of any adverse
7 incidents involving patients and staff. Datix was also
8 reviewed in a similar way at ward level through monthly
9 meetings. I felt staff always had sufficient CPD
10 opportunities as there were always courses being 14:50
11 offered by the Belfast Trust, including study days,
12 which staff were always encouraged to attend. Staff
13 could also request additional CPD if they wished.
14
15 In my last few years at MAH, support from the Belfast 14:50
16 Trust Directors, Co-Directors, Chief Executives,
17 Nursing Director was non-existent as they never came to
18 meet with Ward Managers or visit the wards. I was
19 always raising the concern with senior management,
20 including H823, H77, H377, H290 and H507 about staffing 14:50
21 issues that were affecting the care of patients. They
22 reminded me that due to the change in the hospital
23 wards, including ward closures and resettlement of
24 patients, this meant posts were temporary and were not
25 attractive to potential applicants. Staff who were in 14:51
26 temporary posts were moving on to permanent posts
27 outside of the hospital. I spent a lot of time ringing
28 staff to cover other shifts and it felt like it was
29 never ending. A lot of staff in the hospital felt

1 obliged to complete overtime or additional bank shifts
2 to ensure patient safety. However, this resulted in
3 staff becoming burnt out.
4
5 In my role as a Band 7, we knew as much about RQIA 14:51
6 inspections as we did at any other time, which was
7 either very little if we were notified in advance or
8 none at all if the inspection was unannounced. We knew
9 they were there to inspect the quality of care being
10 provided to patients. In order to prepare for the 14:52
11 inspections, I spoke with staff, in particular
12 patient's named nurses to let them know an inspection
13 was due and to ensure that patients care plans were up
14 to date and that all risk assessments were also up to
15 date. 14:52
16
17 It was rare that the Belfast Trust directors,
18 co-directors et cetera, would have been on the wards on
19 a regular basis. I do not recall seeing any in my last
20 two years working on Killead Ward. H77, who was my 14:52
21 Senior Nurse Manager, did regularly attend the ward a
22 few times a week, even if I were not on duty, to speak
23 with staff and patients. This allowed staff and
24 patients to feel supported by the Senior Nurse Manager
25 for the ward and allowed them to discuss any concerns 14:52
26 or issues they may have had. When H507 took over from
27 H359 as Service Manager around 2012, it was a rare
28 occurrence to see her on the ward and an even rarer
29 occurrence to see her interacting with junior staff or

1 patients. She was never as present on the wards or
2 deemed as supportive as MAH's previous nursing services
3 manager, H359. I felt this was a big loss in terms of
4 support to staff, particularly the junior staff.
5 14:53
6 It was around this time that things started to slip at
7 MAH and things felt very unsettled. Wards were
8 closing, staff numbers were at their lowest and so was
9 morale. Aside from the ongoing staffing issues, staff
10 sickness was increasing and requests from staff to be 14:53
11 moved to different wards were also increasing. When
12 wards were closing and merging with others, staff were
13 told on short notice. I would get a call to say what
14 was happening and that was it. There was no
15 preparation in advance and staff come along with 14:54
16 patients, and, while they were supported as much as
17 possible by myself, there was still not enough
18 resources to run the wards to the best we could have.
19 I recall a particular senior nurse meeting H507 to tell
20 us that Finglass Ward was closing and beds throughout 14:54
21 the hospital would be allocated accordingly despite the
22 other wards not being deemed suitable for these
23 patients.
24
25 I have been quite shocked and saddened to hear about 14:54
26 the alleged abusive treatment endured by some patients
27 by staff. This was not the MAH that I knew and loved
28 working in for many years. Staff at MAH encountered a
29 lot of aggression during their shifts from patients,

1 including verbal and physical abuse. Staff would have
2 been slapped, spat on, had their hair pulled and
3 endured more serious assaults. There were times when
4 staff members would have to go off on short-term or
5 long-term sick after an incident where a patient became 14:55
6 physically aggressive towards them. This is something
7 I feel should also be looked at, as well as the alleged
8 ill-treatment of patients."
9
10 The witness then goes on to say that they don't wish to 14:55
11 give evidence and they provide a signed declaration of
12 truth and that concludes the evidence of A6.
13 CHAIRPERSON: Yes, all right. Well, thank you very
14 much indeed, that brings us to 3 o'clock. There is
15 nothing else to read this afternoon, I don't think? 14:55
16 MS. BERGIN: No.
17 CHAIRPERSON: And we have a live witness tomorrow.
18 MS. BERGIN: Yes, sir.
19 CHAIRPERSON: A7.
20 MS. BERGIN: Yes, Chair, I will be dealing with A7. 14:55
21 CHAIRPERSON: So we will meet again, she will take a
22 good part of the morning.
23 MS. BERGIN: Yes, but not particularly long.
24 CHAIRPERSON: No, all right. Okay. Right. Thank you
25 everybody. 10 o'clock tomorrow. Thank you. 14:56
26
27 THE INQUIRY ADJOURNED UNTIL 10:00AM ON TUESDAY, 20TH
28 FEBRUARY 2024
29